

ARMY 2020

Generating Health &
Discipline in the Force
Ahead of the Strategic Reset

REPORT 2012



Report Documentation Page			<i>Form Approved OMB No. 0704-0188</i>	
<p>Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.</p>				
1. REPORT DATE 2012	2. REPORT TYPE	3. DATES COVERED 00-00-2012 to 00-00-2012		
4. TITLE AND SUBTITLE Army 2020: Generating Health & Discipline In The Force Ahead Of The Strategic Reset		5a. CONTRACT NUMBER		
		5b. GRANT NUMBER		
		5c. PROGRAM ELEMENT NUMBER		
6. AUTHOR(S)		5d. PROJECT NUMBER		
		5e. TASK NUMBER		
		5f. WORK UNIT NUMBER		
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Headquarters, Department of the Army,1400 Defense Pentagon,Washington,DC,20301		8. PERFORMING ORGANIZATION REPORT NUMBER		
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)		10. SPONSOR/MONITOR'S ACRONYM(S)		
		11. SPONSOR/MONITOR'S REPORT NUMBER(S)		
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited				
13. SUPPLEMENTARY NOTES				
14. ABSTRACT				
15. SUBJECT TERMS				
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 212
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified	19a. NAME OF RESPONSIBLE PERSON	

This page has been left blank intentionally.

ARMY 2020

Generating Health & Discipline in the Force Ahead of the Strategic Reset

REPORT 2012



HEADQUARTERS, DEPARTMENT OF THE ARMY

This page has been left blank intentionally.

VCSA Sends

Leaders,

While still waging the longest war in our Nation's history, hard fought in two separate theaters, we have begun the challenging task of reintegrating our Soldiers, resetting our equipment, and returning our primary focus to training and preparing for future contingency operations. While much can be learned from our previous post-conflict eras, current circumstances and conditions are unique and must be addressed within today's environment. In many ways, the most difficult work lies ahead. The Army calls on you, as professional leaders, to ensure a successful reset of the Force. We must work together in an informed and synchronized effort to address the unique challenges facing today's Army. This report will provide context, identify challenges and inform and educate you on the current status of the health and discipline of our Soldiers, Families and Veterans. In short, it will serve as a valuable roadmap for leaders, commanders and service providers alike, paving the way to success in the days ahead.

Nearly two years ago, the Army published the *Health Promotion, Risk Reduction, Suicide Prevention Report 2010*, referred to as the *Red Book*, which provided the first comprehensive review of the health and discipline of the Force. The following report continues—and in many ways expands—that dialogue, providing a thorough assessment of what we have learned with respect to physical and behavioral health conditions, disciplinary problems, and gaps in Army policy and policy implementation. It provides important information on the challenges confronting our Soldiers and Families, challenges that we must collectively address to reduce the stress on the Force, promote Soldier health and discipline and improve unit readiness. To this end, this report is designed to educate leaders, illuminate critical issues that still must be addressed and provides guidance to leaders who are grappling with these issues on a day-to-day basis.

Many of the issues addressed in this report are complex, especially those related to healthcare. One of the most important lessons learned in recent years is that we cannot simply deal with health or discipline in isolation; these issues are interrelated and will require interdisciplinary solutions. For example, a Soldier committing domestic violence may be suffering from undiagnosed post-traumatic stress. He may also be abusing alcohol in an attempt to self medicate to relieve his symptoms. The reality is there are a significant number of Soldiers with a foot in both camps—health and discipline—who will require appropriate health referrals and disciplinary accountability. This will require us to sharpen our surveillance, detection and response systems to ensure early intervention. The necessary response to health and accountability will require active communication and collaboration among commanders, service providers and our Soldiers and Families.

Without doubt there are challenging days ahead. The majority of our Soldiers and Families remain strong and resilient; however, many are struggling with wounds, injuries and illnesses incurred during multiple combat deployments. Through our untiring commitment to researching and resourcing healthcare initiatives—particularly those related to the stressors of combat, we know more today about these conditions than ever before. As the Army continues to advance medical science, including advances in brain and musculoskeletal research, we will look to you to remain abreast of these advances, educate yourself and your subordinates, and adapt your skills to improve Soldier and Family care. Make no mistake, these conditions are real; in recognizing that, we must take meaningful steps to reduce stigma associated with seeking treatment.

Given the complex nature of issues affecting today's Soldier population, we must fulfill our obligation to learn, understand and educate ourselves and subordinate leaders to adapt to today's environment. To do so, you must read this report in its entirety. There are no shortcuts, EXSUMs or CliffsNotes; these are not intuitive topics but represent the synthesis of complex issues that will require interdisciplinary knowledge and implementation. Just as reading Army regulations and field manuals is essential to professional development, reading and understanding this report will help you achieve the bottom line in this business—Soldier and Family readiness. Study this report, ensure your subordinate leaders understand its message, and let's work together to effectively promote health and discipline ahead of the strategic reset.

A handwritten signature in black ink, appearing to read "Chiarelli", with a horizontal line underneath it.

GEN Peter W. Chiarelli

Table of Contents

I – INTRODUCTION TO GENERATING HEALTH AND DISCIPLINE IN THE FORCE AHEAD OF THE STRATEGIC RESET	1
1. Introduction “Why you should read this report...”	1
a. Background of the Health and Discipline of the Force.....	1
b. Purpose of this Report.....	1
c. Assessment of the Health and Discipline of the Force.....	3
d. Complexity of Today’s Challenges.....	3
2. Context “How does it apply to you...”	4
3. Background “What you need to know to understand the report...”	5
a. The Army Population at Risk (Maze)	6
b. The Care Continuum.....	7
4. Organization and Methodology “What you will find in this report...”	8
a. Health of the Force (Chapter II).....	8
b. Discipline of the Force (Chapter III).....	8
c. Synthesis of Army Surveillance, Detection and Response to At-Risk and High-Risk Populations (Chapter IV)	9
d. Quotes	9
e. Vignettes	10
f. Learning Points	10
II – HEALTH OF THE FORCE	11
1. Complexity of an At-Risk Population	12
a. Behavioral Health Diagnoses and Treatment.....	12
b. Impact of Behavioral Health on the Force	13
c. Policy and Programs	14
2. Medical Issues.....	16
a. mTBI.....	16
(1) mTBI (Concussion) is a National Issue.....	17
(2) Impact of TBI on the Force	18
(3) DoD mTBI Protocols	19
(4) The Army’s mTBI Campaign Plan	20
(5) TBI Effects on the Soldier and Family.....	20
(6) mTBI Policy and Programs.....	21
b. Post Traumatic Stress (PTS) and Post Traumatic Stress Disorder (PTSD).....	22
(1) The PTSD Epidemic.....	22
(2) PTSD Rates among Veterans	23

(3) The Impact of PTSD on the Force.....	24
(4) Reducing Stigma Associated with PTSD	25
(5) PTSD Policy and Programs	25
c. Depression	27
(1) Impact of Depression on the Force.....	27
(2) Depression Associated with Other Behavioral Health Issues	28
d. Drug and Alcohol Abuse.....	28
(1) Drug and Alcohol Abuse as a National Issue.....	28
(2) Impact of Drug and Alcohol Abuse on the Force	29
(3) Drug and Alcohol Treatment and Administration	31
(4) Policy and Programs	33
e. Stress.....	35
(1) Army Transitions and Stressors	36
(2) Policy and Programs	41
3. Challenges Facing Army Leaders and Healthcare Providers	42
a. Comorbidity (Polytrauma Triad / Symptoms).....	42
b. Prescription Medications	45
(1) Effects of Medication Nationally	45
(2) Impact of Medication on the Army.....	46
(3) Alternative Pain Management Therapies	48
(4) Policy and Programs	49
c. Suicide	51
(1) Suicide as a National Issue.....	51
(2) Suicide among Military Veterans	53
(3) Impact of Suicide on the Army.....	54
(4) Army Suicides Compared with Other Services	56
(5) Army Awareness of Risk Factors.....	56
(6) Hospitalization for Suicidal Ideation	58
(7) Economic Stressors Affecting the Reserve Component	59
(8) Policy and Programs	61
d. Protected Health Information.....	63
e. Integrated Disability Evaluation System	66
f. Reducing Stigma.....	69
(1) Stigma in the Military.....	69
(2) Policy and Programs	72
4. Army Response to an At-Risk Population	73

a. Wounded Warriors.....	73
b. Developing Resiliency in the Force.....	77
c. HP/RR/SP Research Programs	81
(1) Army STARRS	82
(2) National Intrepid Center of Excellence	82
III – DISCIPLINE OF THE FORCE: THE HIGH-RISK POPULATION [OUTCOMES OF A HIGH-RISK POPULATION].....	85
1. Introduction	85
2. Complexity of High-Risk Behavior.....	87
a. Shifting Perceptions of Criminality.....	87
b. Reducing High-Risk Behavior.....	89
3. Status of Discipline in the Force.....	90
a. Crime in FY2011.....	91
(1) Violent Felony	93
(2) Non-Violent Felony	94
(3) Misdemeanor	95
(4) Crime Demographics in FY2011	97
b. Crime Trends, a Comparison of Crime from FY2006-11.....	99
(1) National Comparison.....	99
(2) Overall, Violent / Non-Violent Felonies and Misdemeanors	100
(a) Violent Felony Crime Trends.....	101
(b) Non-Violent Felony Crime Trends.....	103
(c) Misdemeanor Crime Trends	104
(3) Drug and Alcohol Crime Trends	105
(a) Active Duty Drug and Alcohol Crime Trends.....	107
(b) ARNG and USAR Drug and Alcohol Crime Trends	109
(4) Gaps in Drug Surveillance, Detection and Response Systems	110
(a) Unit Drug Testing	111
(b) MRO Review Process.....	112
(c) Drug Surveillance and Testing Protocols.....	116
(d) Law Enforcement Referrals.....	118
(e) Repeat Drug Offenders FY2006-11	119
(f) Aggregate Drug Crime Estimates	120
(5) Sex Crime Trends.....	121
(a) Violent Sex Crime Trends	122

(b) Other Sex Crimes Trends	123
(c) Seasonality of Sex Crime.....	123
(d) Risk Factors of Sex Crime	124
(e) Investigative Findings for Sex Crime	128
(f) Sexual Harassment / Assault Response and Prevention (SHARP)	129
(6) AWOL / Desertion	129
(a) AWOL.....	130
(b) Desertion	131
c. Multiple Felony Offenders	134
(1) Multiple Felony Offenders Still Serving	135
(2) Separation and Disposition of Multiple Felony Offenders	137
(3) Separation and Disposition of Multiple Drug Offenders	138
d. Death Investigations	140
(1) Homicide and Attempted Murder	140
(2) Suicide.....	141
(3) Equivocal Deaths.....	142
(a) Accidental and Undetermined Deaths	143
(b) Death Trends FY2001-11	144
e. Family Abuse	145
4. Army Response to a High-Risk Population	147
a. Disciplinary Accountability.....	148
b. Administrative Accountability.....	149
(1) DA Form 4833	149
(2) Accession Waivers	151
(3) Flags	154
(4) Separations	155
IV – SYNTHESIS OF ARMY SURVEILLANCE, DETECTION AND RESPONSE TO AT-RISK AND HIGH-RISK POPULATIONS	157
1. Impact of Health and Discipline on Readiness	157
2. Health and Discipline Policy	159
a. Grand Policy Guidance (Health and Discipline)	159
b. Promulgation of Policy (Health and Discipline)	160
(1) Treatment Visibility.....	160
(2) Fitness for Duty Determination and Disability Evaluation.....	161
(3) Separation of Soldiers Medically Unfit for Duty	161
(4) Disciplinary Visibility	161

(a) Perception of Criminality	162
(b) Commander's Court Record (DA Form 4833)	162
(c) Identification of Second-Time Felony Offenders	163
(5) Separation of Multiple Felony Offenders.....	163
(a) Multiple Drug Offenders	164
(b) Prescription Medication Abuse.....	164
(c) Other Multiple Felony Offenders.....	165
3. Health and Discipline-Related Risk Factors.....	165
a. Coupling Health and Discipline.....	165
b. Strategy for Surveilling and Detecting At-Risk and High-Risk Behavior	166
4. The Leadership Role.....	168
a. Communicating and Engaging.....	169
b. Implementing Policy and Programs	169
c. Recommendations for Policy and Program Implementation.....	171
(1) Health and Discipline Surveillance and Detection:	171
(2) Health Promotion and Referral:.....	172
(3) Administrative and Disciplinary Actions:	173
(4) Good Order and Discipline:.....	174
d. A Final Note Regarding Policy Implementation	175
5. Summary.....	175
GLOSSARY OF ABBREVIATIONS.....	177
ENDNOTES	183

List of Figures

Figure I-1: Purpose, Scope and Limitations of Report.....	2
Figure I-2: Health and Disciplinary Maze Model	6
Figure I-3: Event Cycle and Care Continuum.....	7
Figure II-1: Incidence Rates of Mental Disorder Diagnoses, Active Component	13
Figure II-2: Relative Duty Years Lost Due To Mental Disorder Hospitalization	14
Figure II-3: Active Component Medical Encounters and Hospital Bed Days for CY10	14
Figure II-4: Behavioral Healthcare Touch Points	15
Figure II-5: Brain Images.....	16
Figure II-6: Impact of TBI on the Force.....	18
Figure II-7: Alcohol Recidivism Rates, FY01-10.....	31
Figure II-8: Chapters 9 and 14, FY01-11	33
Figure II-9: The Human Function Curve.....	35
Figure II-10: Composite Life Cycle Model.....	36
Figure II-11: Months of Dwell Time	37
Figure II-12: Composite Life Cycle Model (Abbreviated)	40
Figure II-13: Prevalence of Chronic Pain, PTSD and TBI	42
Figure II-14: Overlapping of Multiple Health Issues	43
Figure II-15: mTBI, PTSD and Chronic Pain Symptoms.....	43
Figure II-16: Causes of Death (Civilian Population)	46
Figure II-17: Prescription Medication, FY10 vs. FY11	47
Figure II-18: National Suicide Rate	52
Figure II-19: Active Duty Suicide Deaths	54
Figure II-20: Army Suicides, FY08-11	55
Figure II-21: Active Duty Suicide Rates Across Services	56
Figure II-22: Active Duty Suicide Attempt and Death Stressors.....	57
Figure II-23: Hospitalizations for Suicidal Ideation.....	59
Figure II-24: Unemployment Recovery	59
Figure II-25: Unemployment Rate by Age Group	60
Figure II-26: Suicide Rate vs. Unemployment Rate	61
Figure II-27: WTU and CBWTU Locations	73
Figure II-28: WCTP Comprehensive Transition Plan.....	74
Figure II-29: WTU Population	75
Figure II-30: Warrior Transition Length of Stay	75
Figure II-31: AW2 Program	76
Figure II-32: Treat Risk vs. Enhance Strength	79
Figure II-33: Visits to a Primary Care provider by Emotion Fitness Score	79

Figure III-1: Army Crime Clock	86
Figure III-2: FY11 Offenses and Offenders	92
Figure III-3: FY11 Violent Felony Offenses	93
Figure III-4: FY11 Non-Violent Felony Offenses	94
Figure III-5: FY11 Misdemeanor Offenses	96
Figure III-6: FY11 Offender Grade Composition	98
Figure III-7: FY11 Victims of Violent Crimes	98
Figure III-8: Active Duty vs. National Crime Trends, CY06-11	99
Figure III-9: Overall Crime Trends, FY06-11	101
Figure III-10: Violent Felony Trends, FY06-11	102
Figure III-11: Unique Victims vs. Offenders of Violent Felony Crimes, FY06-11	103
Figure III-12: Non-Violent Felony Trends, FY06-11	104
Figure III-13: Misdemeanor Trends, FY06-11	105
Figure III-14: AD Alcohol and Drug Offenses per Capita, FY06-11	107
Figure III-15: Drug Crime Composition, FY06-11	108
Figure III-16: Illicit Positive Rate by Duty Status, FY06-11	109
Figure III-17: Number of Active Duty Soldiers Missing Annual Urinalysis Testing	111
Figure III-18: Drug Testing and Drug Use Crimes – Monthly Patterns, FY06-11	111
Figure III-19: Positive UAs for Pharmaceuticals vs. Street, FY01-11	112
Figure III-20: FY01-11 MRO Reviews and Authorized Use Numbers	113
Figure III-21: MRO Completion Rates for AD Soldiers	115
Figure III-22: Gap in Drug Reporting	118
Figure III-23: Drug Trends – Wrongful Use of Marijuana, CID vs. MPI Reporting	118
Figure III-24: Active Duty and Reserve Component Drug Testing Data, FY06-11	119
Figure III-25: Sex Crimes (Number of Offenses) Committed by AD Soldiers	121
Figure III-26: Violent Sex Crime Trends: Average Monthly Offenses / 100,000	122
Figure III-27: Violent Sex Crimes, October-February Monthly Trends	123
Figure III-28: FY06-11 Quarterly Sex Crime Trends	124
Figure III-29: Female AD Victims of Violent Sex Crimes	125
Figure III-30: Violent Sex Crimes by Day of Week	126
Figure III-31: Violent Sex Crimes Investigative Findings (Soldier Victims Only)	128
Figure III-32: AWOL and Desertions, FY2006-11	130
Figure III-33: Number of Active Warrants for Desertion	131
Figure III-34: Desertion by Time in Service, All Desertions from FY2006-11	131
Figure III-35: Desertion Return-to-Military Control (RMC)	132
Figure III-36: Size of Multiple Felony Population Over Time	134
Figure III-37: Status of Multiple Felony Offenders	135
Figure III-38: Time Between First and Last Felony Events	136

Figure III-39: Profile of 4,877 Multiple Felony Offenders Who are Still in the Army	137
Figure III-40: Disposition of 19,842 Separated Multiple Felony Offenders.....	138
Figure III-41: Status of Multiple Drug Offenders.....	139
Figure III-42: Homicide and Attempted Murder Offenses	140
Figure III-43: Criminal History and Alcohol / Drug Involvement in AD Suicides.....	141
Figure III-44: Accidental / Undetermined Deaths, FY06-11	143
Figure III-45: Manner of Death, FY01-11.....	144
Figure III-46: Domestic Violence and Child Abuse Incidents.....	145
Figure III-47: Alcohol Involvement in Domestic Violence and Child Abuse	146
Figure III-48: Domestic Violence Recidivism	146
Figure III-49: AC Indiscipline Trends, FY06-11	148
Figure III-50: 4833 Referral Status (CID Data Only).....	150
Figure III-51: Drug / Alcohol and Conduct Accession Waivers, FY04-11	152
Figure III-52: Crime Comparison of Soldiers with Conduct and Drug Waivers vs. No Waivers.....	153
Figure III-53: Total Chapter Separations.....	155
Figure IV-1: US Army's Deployable Inventory	158
Figure IV-2: Health and Disciplinary Policy Promulgation Model	159
Figure IV-3: Health and Disciplinary Maze Model.....	166
Figure IV-4: At-Risk and High-Risk Perspective (Orb Chart)	167
Figure IV-5: Targeting High-Risk Behavior.....	168

I – Introduction to Generating Health and Discipline in the Force Ahead of the Strategic Reset

1. Introduction | “Why you should read this report...”

After more than a decade of conflict, hard fought in two separate theaters, the Army is preparing to transition from a wartime Army to one predominantly training and preparing for future contingencies. This transition represents an enormous undertaking with the operational Army preparing to integrate and readjust back into its institutional base to reconstitute, draw down and replenish its readiness levels as part of its strategic reset. This equates to the reintegration of over 1.1 million Soldiers back into military installations and local communities, back to conducting essential services, training or resuming their civilian occupations. The strategic reset will be a time of change and challenge. Leaders will plan and execute this reset in the wake of tectonic shifts associated with the Force reduction, severe budgetary constraints, the massive military-civilian transition (of a magnitude not seen in more than two decades), the return to personnel and equipping readiness and the regeneration of the health and discipline of the Force. The latter, the health and discipline of the Force, is perhaps the most critical aspect of the strategic reset—and the principal topic of this report—because the Army, unlike the Navy and Air Force, which are platform-centric, is a personnel-centric force. And its readiness is a direct reflection of the health and discipline of the men and women serving in its ranks.

a. Background of the Health and Discipline of the Force

Army senior leaders have been preparing for the strategic reset over the last few years, even while sustaining Title 10 support to contingency operations in Afghanistan and Iraq. They have been mindful of the appreciable ‘wear and tear’ Soldiers and equipment have accrued over ten years of war fought in extremely difficult and demanding environments. Early signs of these effects on Soldiers and Families prompted the establishment of the Army Health Promotion and Risk Reduction (HP&RR) Task Force in early 2009. After 18 months, the body of its work—findings and conclusions, lessons learned and recommendations—were published in the *Health Promotion, Risk Reduction and Suicide Prevention (HP/RR/SP), Report 2010*, also known as the *Red Book*. The report reaffirmed Army efforts to reduce stress on the Force, presumably related to the demands of a wartime operational tempo (OPTEMPO), and most often associated with combat-related wounds, injuries and illnesses; repetitive and lengthy separations; and broader economic conditions. Analyses suggest that this stress was increasingly placing Soldiers at risk, Soldiers who were suffering from physical and behavioral health issues and in need of more vigilant leader oversight, risk mitigation and medical healthcare. But it also discovered a growing high-risk population of Soldiers engaging in criminal and high-risk behavior with increasingly more severe outcomes including violent crime, suicide attempts and suicide, and accidental death.

b. Purpose of this Report

The audience for this report spans leaders at all levels and across most disciplines including Army staff, field commanders, healthcare and risk reduction program managers and other leaders who require a better understanding of the challenges currently facing the Force. It is written in the spirit of a professional academic trade journal but with critically important operational application. It is organized to allow readers to navigate depending on their interest, occupational level or time available as outlined under *Organization and Methodology, “What you will find in this report...”* The purpose of this report is

threefold: inform and educate, assess policy and programs and to balance perception regarding health and discipline (as highlighted in the table below).

Purpose	Scope and Limitations
<p>1. <i>Inform and Educate</i>—to educate leaders in the rapidly evolving nature of the Army population. The health and discipline of the Force is entering a unique phase in a post-war environment, where the Army remains closely aligned to the recent effects of the war; with Soldiers and Families still suffering from the effects of deployment and combat-related wounds, injuries and illnesses; and with leaders grappling with the trade offs—and often inconsistencies—between recovery and readiness.</p>	<p>This is a lengthy and at times complex report that covers critically complex issues associated with the health and discipline of the Force. It overviews topics every leader will recognize, that many are grappling with, and which most want to better understand. Although complex, the discussion of policy (in current context) is far simpler than its anticipated execution (in future context) by leaders in the months and years to come.</p>
<p>2. <i>Assess Policy and Programs</i>—to provide an assessment of the effectiveness of health and disciplinary policy and programs as well as their implementation by leaders throughout the Force. This report provides learning points and offers a few recommendations based on its assessment that will assist leaders in preparing Soldiers and Families for the strategic reset.</p>	<p>This report does not specifically cover all personnel, medical and disciplinary policy (comprised of thousands of effective policy strands), but rather provides a general assessment of the more significant and recent policy changes designed to improve health and discipline.</p>
<p>3. <i>Balance Perception regarding Health and Discipline</i>—to provide context to health and disciplinary issues affecting Soldiers and Families as well their impact on the Force. This report provides critical insight into health and disciplinary issues that may help inform balanced decisions regarding Soldier rehabilitation, treatment, retention and transition.</p>	<p>While it highlights the importance of “performance” in addressing questions of Soldier disposition, it cannot capture the innumerable variables, conditions nor circumstances affecting these decisions.</p>

Figure I-1: Purpose, Scope and Limitations of Report



“We cannot break faith with our men and women in uniform; the all-volunteer force is central to a strong military and central to our nation's future.”

— *The Honorable Leon E. Panetta
Secretary of Defense*

c. Assessment of the Health and Discipline of the Force

This report provides an honest, thorough and unvarnished look at current conditions across the Force. It examines the prevalence of behavioral health issues, incidents of criminal misconduct, as well as relevant rates and trends over the last several years. It reviews new policy and programs put in place to address identified gaps. Additionally it provides an overall assessment of their impact on improving Soldier health and readiness. Toward this end, this report provides a snapshot of conditions through FY2011 but recognizes that Headquarters, Department of the Army (HQDA) will continue to formulate and promulgate new policy to shape the future Force. In order for these policy and program changes to be effective, however, commanders and leaders (at every level) must be knowledgeable of these emerging requirements and take an active role in ensuring compliance.

Army leaders have a small window in which they can reshape the challenges of the strategic reset into opportunities to reset the Army as a smaller, more agile and ready Force. They must execute the Force reduction and military-civilian transition of as many as ~50,000 Soldiers while under tight fiscal and time constraints. Leaders must selectively retain experienced professionals capable of enduring the continued OPTEMPO-stressors of military life, transition Soldiers with physical and behavioral health issues that limit military performance to Department of Veterans Affairs (VA) healthcare, and deselect and separate those whose high-risk behavior continues to place themselves and others at risk. These leadership tasks entail hard decisions that must be informed by fair and equitable policies and programs. And these policies and programs must be clarified and adjusted now if field leaders are to execute Force reduction and transition objectives consistently over the next few years. It will also take this level of early preparation to ensure that leaders can make the necessary adjustments at local levels to facilitate Soldier and Family care, especially for those suffering from wounds, injuries and illnesses incurred in service to the Army and this Nation.

In the final analysis, this report tells two stories; one indicating remarkable improvements and progress in increasing health and discipline, while the other demonstrating that there is still much work to be done to move forward in concentrated areas of policy and program implementation. As highlighted throughout this report, however, the timing and conditions are right to merge both stories into a single and favorable ending.

d. Complexity of Today's Challenges



“While we have made tremendous strides over the past decade, there is much work still to be done. This war, as we often hear it described, is a marathon, not a sprint. And, as I mentioned, many of our biggest challenges lie ahead after our Soldiers return home and begin the process of reintegrating back into their units, Families and communities.”

— GEN Peter Chiarelli
Vice Chief of Staff, Army

The wars in Iraq and Afghanistan are unique in many ways. They represent not only the longest wars fought by our Army, but also the longest fought by an all-volunteer force. Today's wars have placed tremendous and unique burdens on our Soldiers and Families as compared to previous conflicts. Past wars were generally noted for several days of intense combat followed by lengthy periods of military inactivity. According to some estimates, the average infantryman in the South Pacific during

World War II saw about 40 days of combat in four years.¹ In contrast, the OPTEMPO in Iraq and Afghanistan over the past decade has remained persistently high, providing very few opportunities for individuals to rest, either physically or mentally. Most Soldiers today have deployed at least once; many have deployed two or more times on 12-15 month rotations. Nearly two-thirds of those Soldiers who deployed had less than 24 months of “dwell” time spent back at home, resetting, retraining, and recuperating before deploying again. Simply stated, for over a decade nearly every leader and Soldier serving in our Army has lived in a near constant state of anticipation – whether anticipating an upcoming deployment, anticipating the next mission or convoy, or anticipating the challenges of returning home. The prolonged stress and strain on them – and on their Families – must be effectively addressed.

One of the most important lessons the Army has learned is that many health and disciplinary issues, ranging from post traumatic stress (PTS) to illicit drug use to suicide, are interrelated. To view Soldier misconduct in isolation, for example, fails to capture the real likelihood that the misconduct was related to an untreated physical or behavioral health condition, such as increased aggression associated with PTSD or depression. Likewise, failure to anticipate the impact that medical treatments can have on a Soldier’s propensity for misconduct puts that Soldier at greater risk. For instance, a medical provider who prescribes a Soldier powerful narcotic “painkillers” must recognize and mitigate any potential for addiction and addiction-related misconduct. For this reason, the Army—from senior leaders to frontline supervisors—must foster a culture that facilitates a 360° awareness of the interactions of health and disciplinary issues on individual Soldiers, units and Army communities.

A great deal of progress has already been made by effective and innovative commanders and leaders. For example, leaders have improved administrative and accountability measures to screen over 9,000 Soldiers for mild traumatic brain injury (mTBI) in theater since August 2010, increased behavioral healthcare access by 11%, returned separation and accession waiver rates to their historic norms, and substantially reduced multiple felony offenders on active-duty. Yet there is much work still to be done. In spite of all we have learned and the many policy, process and program improvements made, the Army has not effectively reduced some portions of our high-risk population (suicides, equivocal deaths, crime rates, absences without leave (AWOL), other misdemeanors and vehicle / motorcycle accidents). While disappointing, this should not be cause for alarm or capitulation. We recognized when we began this introspective examination in 2009 that it would take time. After all, any erosion in health and discipline in the Force at the expense of waging war for a decade will take at least a portion of equal time to correct. Also, we cannot discern the potential impact of our efforts in preventing high-risk behavior from data alone. As we continue to reduce the stress on the Force we can expect more positive outcomes with time. Our success will require continued patience, a sustained commitment to health promotion and risk reduction, and active leader involvement at all levels.

2. Context | “How does it apply to you...”



“Soldiers are not IN the Army; Soldiers ARE the Army.”

— GEN Creighton W. Abrams, Jr.
26th Chief of Staff, Army

We now know that if we are to effectively address the innumerable challenges to regenerating the health and discipline within the Force, leaders cannot focus their efforts solely on the extreme outcomes of behavior, but rather on the early indicators that inform their prevention. Leaders and healthcare providers must engage in an interdisciplinary approach, comprised of several lines of effort, with an aim to: (1) increase effectiveness of health surveillance, detection and response efforts to identify, refer and treat Soldiers and Families at risk; (2) reduce cultural stigma associated with seeking behavioral healthcare; and (3) develop resiliency, coping skills and encourage help-seeking behavior among our Soldiers and Families.

In total, this report–

- Provides an in-depth discussion on the most common at-risk behaviors, injuries and health conditions affecting our Force, including mTBI, post traumatic stress disorder (PTSD), poly-pharmacy, depression, stress and suicide;
- Reviews and assesses the Army's high-risk population, as well as improvements made in risk reduction policies, programs and processes;
- Assesses the effectiveness of Army surveillance, detection and response efforts as they pertain to health-related issues, criminal activity, suicide and other high-risk behaviors;
- Evaluates the impact of policy progress and processes changes made in recent years with respect to health promotion and risk reduction (HP&RR) in the Force;
- Provides recommendations and a proposed way ahead with respect to implementing HP&RR-related policy, progress and process improvements across the Force.

As we look ahead to the strategic reset, transitioning from a predominantly wartime Army to a ready and responsive one, leaders at every level must be actively engaged. They must understand the issues addressed in this report, apply the many lessons learned and, unlike the mostly reactive efforts of the post-Vietnam Army, continue to take a proactive approach to generating health and discipline in the Force. This report should serve as a comprehensive guide, a roadmap of sorts reflecting not only how far we have come in recent years, but more importantly, provide direction as we look ahead to the strategic reset and the many challenges we will inevitably face as we come back home.

"As a two-time Garrison Commander, I wish I would have had this document 5-7 years ago!" (Comment made during Army staffing of this report.)

– COL David W. Hall

Deputy Director for Installation Services, ACSIM

Commander USAG-Yongsan 2007-10, Commander USAG-Kaiserslautern, 2002-04

3. Background | “What you need to know to understand the report...”

This report represents a review of the Army's efforts to reduce the impact of at-risk and high-risk behavior since FY2009 with a particular focus on progress since the publication of the *HP/RR/SP Report 2010*. It is not necessary to have read the *Red Book* because this subsequent report reviews critical constructs of the earlier report in order to provide continuity and to ensure this report may be read and understood as a stand-alone document.

As was the case with the *HP/RR/SP Report 2010*, this report was written with varying audiences in mind—HQDA Secretariat and Staff Principals, commanders, leaders, service and program providers, Soldiers, Department of the Army (DA) Civilians, Family members and the public at large. Not all sections are relevant to or necessary for all readers; however, all are encouraged to read the report in its entirety.

This report reflects reviews of available literature regarding issues relevant to health promotion and risk reduction. It presents new and existing Army policies and programs related to health promotion and risk reduction, while analyzing and assessing available and relevant Army data. The report also leverages the expertise of the HP&RR Task Force and other key Army Staff subject matter experts for data, analyses and for formulating recommendations and conclusions.

Some of the models and concepts introduced in the *Red Book* are referenced again in this report. For example, the *Health and Disciplinary Maze Model* depicting the Army's at-risk and high-risk populations at figure I-2 has been updated to reflect data from FY2011. This model depicts the Soldier data in concentric rings that represent increasing severity for potential outcomes as it approaches the center. The model demonstrates an overlap of the two subset populations; at-risk Soldiers in the darker shade, who need and are seeking help and, high-risk Soldiers in the lighter shade, who are not help seeking and whose high-risk behavior endangers themselves and others. The center, in blue, represents suicides and deaths as a result of high-risk behavior.

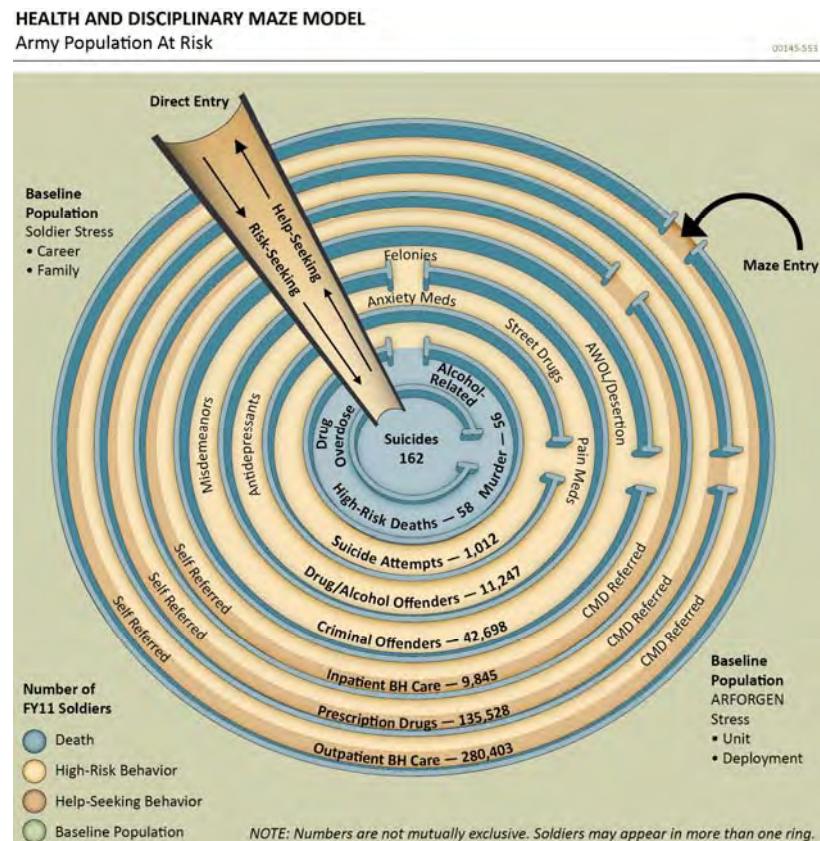


Figure I-2: Health and Disciplinary Maze Model

a. The Army Population at Risk (Maze)

The model is analogous to a maze which illustrates the relationship between risk and adverse outcomes. Each concentric ring or passage adds complexity and increasing potential severity for adverse behavioral outcomes. "At-risk" Soldiers (help-seeking) will generally enter and exit the maze, seeking treatment, recovering and then returning back to the healthy population. "High-risk" Soldiers (not help-seeking), however, may enter and continue to spiral toward the center with increasingly more severe consequences in each subsequent passage. Their escape from the maze will generally require the advent of help-seeking behavior and / or leader intervention to arrest the spiral toward the center.

The maze includes data for both sub-populations in FY2011. The data are *not mutually exclusive*; a single Soldier may be reflected in multiple rings. The first three concentric rings provide data for healthcare with 280,403 Soldiers who received outpatient behavioral healthcare; 135,528 [unique Soldiers] prescriptions (anti-anxiety, anti-depressant and narcotic pain management) for more than 15 days; and 9,845 Soldiers who received inpatient behavioral healthcare. The vast majority of these Soldiers are help-seeking (at-risk) Soldiers who returned to a healthy status, with a minority who were high-risk and who were command referred to healthcare. This is a good news story that demonstrates that the Army has dramatically increased its healthcare capacity, increased leader involvement and quite possibly reduced the stigma associated with physical and behavioral healthcare. It also indicates a renewed commitment to those basic non-combat related leadership skills and practices that have gradually atrophied over the past decade as leaders appropriately focused the majority of their energy and efforts in other areas—namely preparing Soldiers for combat.

The remaining concentric rings represent a high-risk population that exhibited increasingly high-risk behavior. The high-risk population comprised of 42,698 criminal offenders, 11,247 drug and alcohol offenders, 1,012 suicide attempts, 114 high-risk deaths and murders, and 162 suicides. While both populations require appropriate command involvement and effective healthcare, the high-risk sub-population is at the greatest risk for adverse outcomes. Consequently, the high-risk sub-population remains (literally and figuratively) at the center of the maze and is the focus of the Army's mitigation efforts.

b. The Care Continuum

Another key concept introduced in the *Red Book* and referenced in this report is the *Event Cycle and Care Continuum* (figure I-3) used to illustrate how Army



Figure I-3: Event Cycle and Care Continuum

leaders respond to at-risk and high-risk Soldiers. The cycle and continuum are complementary to one another, with each phase of the Care Continuum nested below the Event Cycle, as it corresponds to the pre-event, inter-event, or post-event stage. The Event Cycle depicts the sequence of events affecting the Soldier, while the Care Continuum depicts the institution's response to each event. Taken together, the Event Cycle and Care Continuum provide a sequential methodology to align the appropriate health and disciplinary response to Soldiers at each point along the continuum. The institutional goal, with respect to manning, training and equipping the Force, should be to keep all individuals in the awareness and resiliency components of the pre-event stage, recognizing that for a person to be in the inter-event stage something must have occurred (e.g., rape, mTBI, assault). In order to do so, leaders must ensure proactive surveillance and detection systems and an immediate response to mitigate and reduce the impact of risks associated with health and disciplinary issues in the inter- and post-event stages.

The Event Cycle and Care Continuum highlight the importance of implementing the following strategy: Army leaders must increase surveillance and detection of indicators associated with a potential or actual event and then respond accordingly—first, to promote the health of the Soldier and Family; second, to hold the Soldier accountable as appropriate.

4. Organization and Methodology | “What you will find in this report...”

This report is presented in four chapters, which may be read in sequence or separately by topic or section, followed by a glossary of abbreviations and acronyms. Each section, summarized below, is more valuable to leaders if read in the context of the entire report. For example, the messages in Chapter II, *Health of the Force*, and Chapter III, *Discipline of the Force*, provide common themes regarding the interdependent nature of health and disciplinary risks, and the corresponding policy, programs and leader execution required to reduce their effects. The synthesis of these messages in Chapter IV, *Synthesis of Army Surveillance, Detection and Response to At-Risk and High-Risk Populations*, illustrates the unity of effort required in the way ahead to improve health and discipline in the post-war period. Quotes, vignettes and learning points are dispersed throughout the entire report. They serve to humanize this report which is replete with compelling and gripping data and statistics. While important, the intent is that the data and statistics not become the story; the Soldier, unit or Family who are living these issues are the focus of this story.

a. Health of the Force (Chapter II)

There are many elements within the broad scope of the health of the Force, particularly when viewed within the context of a decade of war. The complexity of physical and behavioral health conditions, most often from combat-related wounds, injuries and illnesses, and their potential adverse effect on Soldier behavior, performance or readiness is provided in detail. It demonstrates that the Army has made vast improvements over the last few years in understanding and countering the effects of many of these physical and behavioral health conditions, namely mTBI, PTS, depression and chronic pain, among others, and their related symptoms and manifestations. It provides information with respect to policy and programs that every leader must know to contend with the challenges of leading Soldiers in a post-war period. It concludes each sub-section with learning points and a few recommendations to arm commanders, healthcare / program providers and Soldiers, who compose the “Health Triad,” with knowledge and improved awareness in order to increase surveillance and detection of at-risk Soldiers and inform an appropriate response to ensure early intervention, mitigation and treatment. Ultimately, the objective is to improve post-war health and to set the stage for the Force of 2020.

b. Discipline of the Force (Chapter III)

The stress and strain on our Force after a decade of conflict waged in high-risk, high-adrenaline combat environments continues to play out in the increased incidence of high-risk behavior. The Army saw a subtle rise in overall crime comprised of violent felonies, non-violent felonies and misdemeanors from FY2010-11, though crime still remains below levels set in FY2008-09. Of particular concern is the continued high incidence of both violent sex crimes and drug offenses. These and other high-risk behavior are likely outcomes of a variety of factors including intentional misconduct, lax / unchecked discipline, post combat adrenaline, high levels of stress and potential behavioral health issues. Sustained levels of crime and high-risk behavior are a concern, moreover, because crime generates more crime; misdemeanors are a precursor to more serious crimes and any crime can be transmitted to others. Misdemeanors and lower levels of risk taking behavior such as traffic offenses, for example, have proven to have serious and even fatal consequences. The Army continues to make progress in many policy and program areas but gaps remain in surveillance, detection and response systems that adversely affect their implementation. This chapter highlights these gaps and, through quantitative analyses, estimates their potential impact on the discipline of the Force. It provides robust data and

trend analysis (lagging indicators) which provide a barometer of Army progress. Each subsection highlights progress as well as those areas that still require improvement. It reminds experienced leaders and educates young leaders on the interdependent nature of surveillance, detection and response systems that, if routinely implemented, will reduce criminal and high-risk behavior in line with historic norms. It also provides lessons learned and highlights a few learning points that will be essential in closing the gaps in these systems.

c. Synthesis of Army Surveillance, Detection and Response to At-Risk and High-Risk Populations (Chapter IV)

This chapter discusses policy and programs at the crossroads of health and discipline. It emphasizes the dual requirement to promote health and maintain accountability across the Force. In the wake of looming Force reductions and severe fiscal constraints, Army leaders must formulate clear policy regarding Soldier retention and program continuation. Policy must clearly define readiness standards to inform leader options in determining health and disciplinary thresholds for appropriate Soldier disposition, retention and transition. In order to enforce these standards, leaders must have a firm understanding of the impacts of Soldier health and discipline, treatment and rehabilitation programs and Soldier accountability on the Force. Decisions must be performance-based and address fundamental questions regarding readiness: Are Soldiers medically fit to perform their duties? Will rehabilitation return Soldiers to Army performance standards? Will administrative and disciplinary measures shape future performance?

The challenge ahead for our Army will be to ensure the right recommendations are heeded, implemented and enforced at the appropriate levels. Success will ultimately depend upon commanders and (installation) program managers taking an active, engaged role, both “on-duty” and “off-duty,” in garrison and combat environments, in order to detect and effectively address at-risk and high-risk behavior related to the health and discipline of the Force. To this end, this chapter concludes this report with three sections designed to improve policy and policy implementation through: (1) five overarching recommendations (the only recommendations proffered in this report) to refine strategic policy; (2) a holistic strategy to improve surveillance, detection and response systems; and (3) a summary of unit-level policy actions for commanders and program managers to improve health and disciplinary processes across the Force.

d. Quotes

Improvements and current progress of Army health and disciplinary policy and its implementation are a direct result of senior leader engagement among Army and other leaders who recognize its importance and who are working in a collaborative environment to enhance the quality of life of Soldiers and their Families. Quotes from these leaders are included throughout this document, as an example of their strategic guidance, oversight and involvement. The quotes are aligned with appropriate topics to add relevance and context to the report’s dialogue.



“Trust is the bedrock of our honored profession -- trust between each other, trust between Soldiers and leaders, trust between Soldiers and their Families and the Army, and trust with the American people.”²

– GEN Raymond T. Odierno
Chief of Staff, Army
Expectations for the Future

e. Vignettes

Vignettes provide the real life stories that substantiate the findings and enhance the topical discussions of this report. Many of these stories are very traumatic but serve to put the face and voice of Soldiers within the context of this report and to remind leaders of the importance and urgency of health and disciplinary policy and program implementation.

VIGNETTE— NCO RELIES ON TRAINING TO PREVENT SUICIDE³

A SSG observed a Soldier attempting to purchase cigarettes without his ID at a Fort Hood shopette. The SSG detected the odor of alcohol and suggested the Soldier leave. The Soldier then asked him if he could speak with him once he (the SSG) was done with his purchase. The SSG quickly noticed the Soldier looked rough as if he had been in a fight. The Soldier kept telling him that he “was done.” When the Soldier stated “I just reenlisted, but I’m done, if you know what I mean,” the SSG realized what the Soldier was implying, knew he required help and quickly called upon his Ask, Care and Escort (ACE) training. He contacted the Military Police (MP) and safeguarded the Soldier until they arrived.

In October 2011, the SSG was commended by the Commanding General (CG), III Corps and Fort Hood, who stated “It is because of [his] quick actions that a Fort Hood team member is getting the help he needs and deserves....we must all have the courage to help a buddy.” The SSG commented, “I had a job to do and somewhere to go, but in the end, I’m glad I stuck around to talk to this individual. If your battle buddy is hurting in anyway, you know how to go out and get him some help.”

f. Learning Points

Learning points are provided in lieu of recommendations. Most leaders already understand and are working to implement the recommendations outlined in the *Red Book*; these learning points are provided as key summary points at the end of each subsection.

LEARNING POINTS

- ★ “Nearly 1 in 12 high school seniors reported nonmedical use of Vicodin and 1 in 20 reported abuse of OxyContin.” This is a particular concern for the Army as it represents an increasingly permissive attitude among a subset within the Army’s recruiting population.
- ★ There is a significant shortage of psychologists, psychiatrists and other behavioral healthcare providers, not only within the military healthcare system but nationwide.
- ★ High-risk behavior (such as substance abuse or aggression) viewed in isolation may be misperceived as potential misconduct rather than behavior associated with physical or behavioral health issues.

II – Health of the Force



“The most important thing we do is take care of Soldiers, Civilians and Families. However, the obvious stress of ten years of war in two theaters, inadequate dwell time at home to recover and reconstitute and myriad attendant issues like high suicide rates, stress on Families and communities and a rising number of non-deployable Soldiers have real implications for the Army today and in the future.”

– *The Honorable John M. McHugh
Secretary of the Army*

This chapter reviews the health of the Force after a decade of war. It discusses the challenges associated with leading a Force that has Soldiers and Families affected by combat-related wounds, injuries and illnesses, operational tempo (OPTEMPO) -related stress, and even pre-service health conditions. Although presented against the backdrop of a larger healthy and very capable Force, these Soldiers will require continued leadership focus, time and other resources to reduce what has become an at-risk population at the margins of the Army’s ready-available manpower pool. This will not be an easy undertaking as the delineation between fit and unfit for duty is not always clear. Many Soldiers who are suffering from behavioral health issues or “invisible wounds” remain undetected throughout the Force, suffering in silence in Army formations at camps, posts and stations and—with the Reserve Component (RC)—across communities nationwide.

A recurring comparison between the Army’s post-Vietnam transition and the current shift from contingency operations in Iraq and Afghanistan provides valuable lessons from the past and informs national leadership of the challenges, relevance and urgency to reset and return to a healthy and ready Force. Dramatic improvements in Soldier protective equipment and combat casualty care since Vietnam have reduced mortality rates on the one hand, while increasing casualty rates for Soldiers suffering from wounds, injuries and behavioral health issues on the other. Operations Enduring Freedom and Iraqi Freedom for example, had a fatality to wounded ratio of 1:5.0 and 1:7.2 as of November 2009, compared to a Vietnam ratio of 1:2.6.⁴ As of 19 September 2011, the Defense Manpower Data Center (DMDC) officially placed total theater Army fatalities at 4,462 and non-fatal casualties at 32,001.⁵ These non-fatal casualty numbers continue to grow as the war persists and as late onset of a variety of behavioral health issues continue to emerge.

The wounded Soldier population data presented above reflect Soldiers identified and evacuated from theater. However, the actual number of injured or ill is substantially larger. As discussed herein, evacuation numbers do not account for the large population of Soldiers who have returned from combat with undiagnosed combat-related injuries and illnesses, nor does it account for other Soldiers suffering from non-combat or deployment-related injuries and illnesses (e.g., training accidents or injuries sustained while off-duty). For example, 9,794 Soldiers were enrolled in Warrior Transition Units (WTU) and Community Based Warrior Transition Units (CBWTU) Army-wide as of October 2011.⁶ Approximately 87% of this population has deployed and 10% were evacuated for a combat-related injury.⁷

This chapter also focuses on the complexity of identifying and diagnosing the Army’s at-risk population; it is a population experiencing both diagnosed and undiagnosed health concerns, including mild traumatic brain injury (mTBI), post traumatic stress disorder (PTSD), depression and anxiety. The

long term effects, care and treatment of this undiagnosed population—not to mention for those diagnosed—may play out as the most significant challenge confronting the Army’s human domain and force readiness as the Army transitions from war.

The implication is clear—the Army will continue to care for Soldiers suffering from deployment-related wounds, injuries and illnesses as it enters its strategic reset and, as discussed later, this effort may continue well into the next decade. Such an undertaking will require the Army to leverage its many improvements in Soldier healthcare; refine its surveillance, detection and response systems to identify and treat Soldiers with undiagnosed physical and behavioral health issues; and expand its transition services to provide a “warm hand-off” from Army to Department of Veterans Affairs (VA) healthcare programs.

Although sobering in terms of the magnitude of a post-war at-risk population, this report also tells a good news story. The Army has made tremendous progress and sweeping change in the few years since the publication of the *Red Book*. The Army, in conjunction with its many research partners, has advanced the science behind surveillance, detection and response of combat-related injuries and behavioral health conditions including mTBI, PTSD, and depression, among others. Senior leaders are engaged in Army-wide health forums from Headquarters, Department of the Army (HQDA) to installations to codify lessons learned from the adverse outcomes of the at-risk population. The Army has developed new policies and programs that add additional protections for Soldiers suffering from physical and behavioral health conditions, undergoing medical therapy, or reluctant to seek help for health related conditions. There is still much that must be done as the Army continues to reduce gaps in surveillance, detection and response systems, but even these remaining gaps signal some good news. The Army is actively measuring with new and more relevant data what it has done, what it is currently doing and what it must do next to effectively promote the health of the Force.

LEARNING POINTS

- ❖ Army progress and momentum in implementing health and risk reduction policies and programs have been strengthened by publication of ALARACT (All Army Activities) 160 / 2010 (Protected Health Information [PHI]) which has increased communication among the health triad (commanders, healthcare / program providers and effected Soldiers).

1. Complexity of an At-Risk Population

a. Behavioral Health Diagnoses and Treatment



“Psychological wounds can be as debilitating as any physical battlefield trauma.”⁸

— *The Honorable Eric Shinseki*
Secretary of Veterans Affairs
July 2010

Behavioral health issues across the Force, including PTSD, depression, substance dependence and others are on the rise. Their impact on Soldiers and Families will fundamentally change leadership requirements for continued surveillance, detection and response in caring for Soldiers through the Army’s strategic reset and beyond. Current research provides a window into the challenges that lay

ahead. One study of 424 Army National Guard (ARNG) Soldiers who were deployed for 16 months in Iraq found that approximately one-third reported post-deployment behavioral health treatment. Unfortunately, of those who screened positive for behavioral health issues, over one half were not receiving behavioral healthcare.⁹ Other research throughout this chapter conveys a similar story but highlights other complexities including undetected and undiagnosed behavioral health issues, coexistence of multiple behavioral health issues, increased high-risk behavior associated with behavioral health conditions, and more.

As highlighted in the outer concentric ring of the *Health and Disciplinary Maze Model* (figure I-2), the Army has increased its outpatient behavioral health access and delivery by more than 10% in FY2011, with a surge in behavioral healthcare from 253,773 individual Soldiers in FY2010 to 280,403 in FY2011. This increase demonstrates the Army's expanded capacity for providing behavioral healthcare, while underscoring the importance it places on behavioral health therapy as a critical element of Army medicine. This is a good news story. Army leadership has communicated that the expansion in behavioral health contacts is essential in maintaining Soldier health in a high-risk occupation associated with a high OPTEMPO environment, sustained deployments and the effects of war. This surge in behavioral healthcare supports a shift in Army healthcare, as senior leaders have recognized the importance of elevating the mental health of the Force to those levels commensurate with the Army's long-standing efforts to sustain the physical health of the Force. In other words, today's leaders recognize the holistic approach of treating both the mind and body.

LEARNING POINTS

- ★ Increased access and delivery of behavioral healthcare are as essential as physical healthcare in the high-risk occupation and high OPTEMPO environment of military service.

b. Impact of Behavioral Health on the Force

As illustrated in figure II-1, a dramatic increase in the incidence and prevalence of behavioral health issues, which contributed to the expansion of the Army's at-risk population, has fueled the growth for expanding Army behavioral healthcare. The chart depicts the incidence rates of mental disorder diagnoses across all Services from CY2000-09. As evident by the green line, behavioral health diagnoses continue to increase among Soldiers, well above the other Services.¹⁰

The increase in behavioral health diagnosis and treatment has been resource intensive as measured by hospital bed days in figures II-2 and II-3. The first figure shows a ~300% increase in duty years lost from CY2000-09 as a result of hospitalization for behavioral health disorders. It also demonstrates that behavioral health inpatient care has increased significantly from CY2006-10, presumably from increased combat intensity but also from improved medical screening and diagnoses as the war continued. The second chart at figure II-3 provides a similar story by comparing physical injuries to behavioral

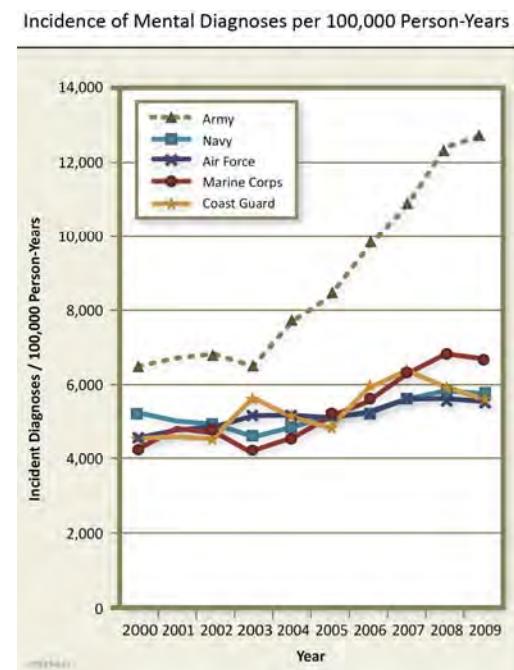


Figure II-1: Incidence Rates of Mental Disorder Diagnoses, Active Component

health conditions as measured by inpatient hospital care in CY2010. It illustrates that while there were significantly fewer “encounters” and “patients” from behavioral health conditions than for physical injuries, behavioral health patients required more than twice the number of hospital days for treatment and recovery. This trend in both inpatient and resource commitment can be expected to continue over the next few years. These charts and other data, moreover, reasonably predict an increase in at-risk outcomes associated with behavioral health issues including reduced Army readiness, Soldier disability and increased Soldier and Family stress.

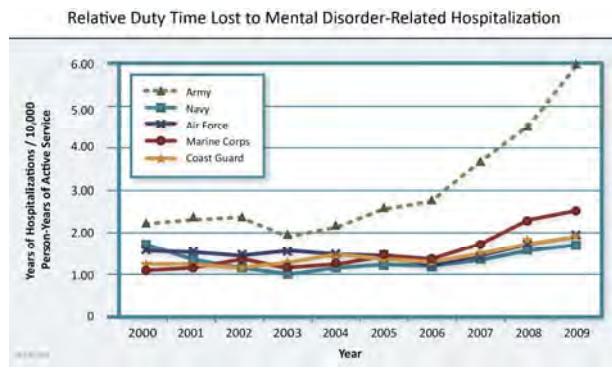


Figure II-2: Relative Duty Years Lost Due To Mental Disorder Hospitalization

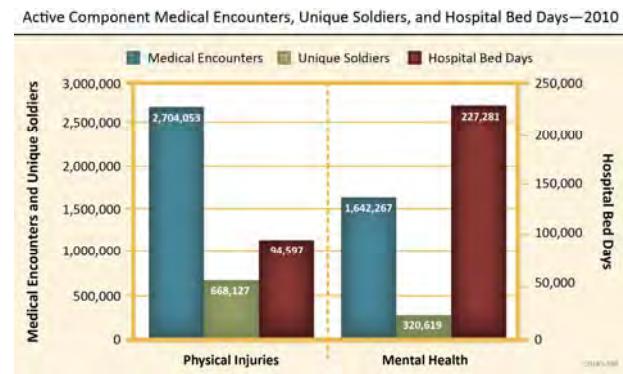


Figure II-3: Active Component Medical Encounters and Hospital Bed Days for CY10¹¹

c. Policy and Programs

In response to the dramatic increase in behavioral health issues, MEDCOM published OPORD 10-70 in September 2010, which established the Army’s behavioral health mission with an overarching goal of reducing behavioral health issues and mitigating the impact of wartime stresses. Its mission statement follows:¹²

MEDCOM conducts a campaign to establish an integrated, coordinated and synchronized comprehensive behavioral health system of care supporting the human element of Army Force Generation (ARFORGEN) in each of its phases in order to reduce the incidence and prevalence of behavioral health issues and mitigate the impact of the normal and abnormal stresses of Army life, deployment and combat.

The model at figure II-4 illustrates the hallmark of MEDCOM’s behavioral health campaign plan referred to as the *Comprehensive Behavioral Health System of Care Campaign Plan*. It depicts the Army’s approach to identifying, preventing, treating and tracking behavioral health issues affecting Soldiers and Families—an approach that every wartime leader will recognize. It emphasizes five touch points to evaluate stress on the Force aligned with the ARFORGEN cycle: from pre-deployment to theater to redeployment / reintegration to a periodic health assessment (conducted annually). It highlights several key tasks as a part of its concept of operation: (1) standardize and synchronize behavioral healthcare and evaluate campaign effectiveness; (2) outline a comprehensive, multidisciplinary approach that focuses on all aspects of behavioral healthcare; (3) reinforce commanders’ ownership, critical tasks and actions; and (4) set conditions to incorporate the Composite Lifecycle Model identified in the *Red Book*, to include identification of stress clusters in the Life Cycle strands of Unit, Soldier and Family (see *Composite Life Cycle Model*, figure II-10).

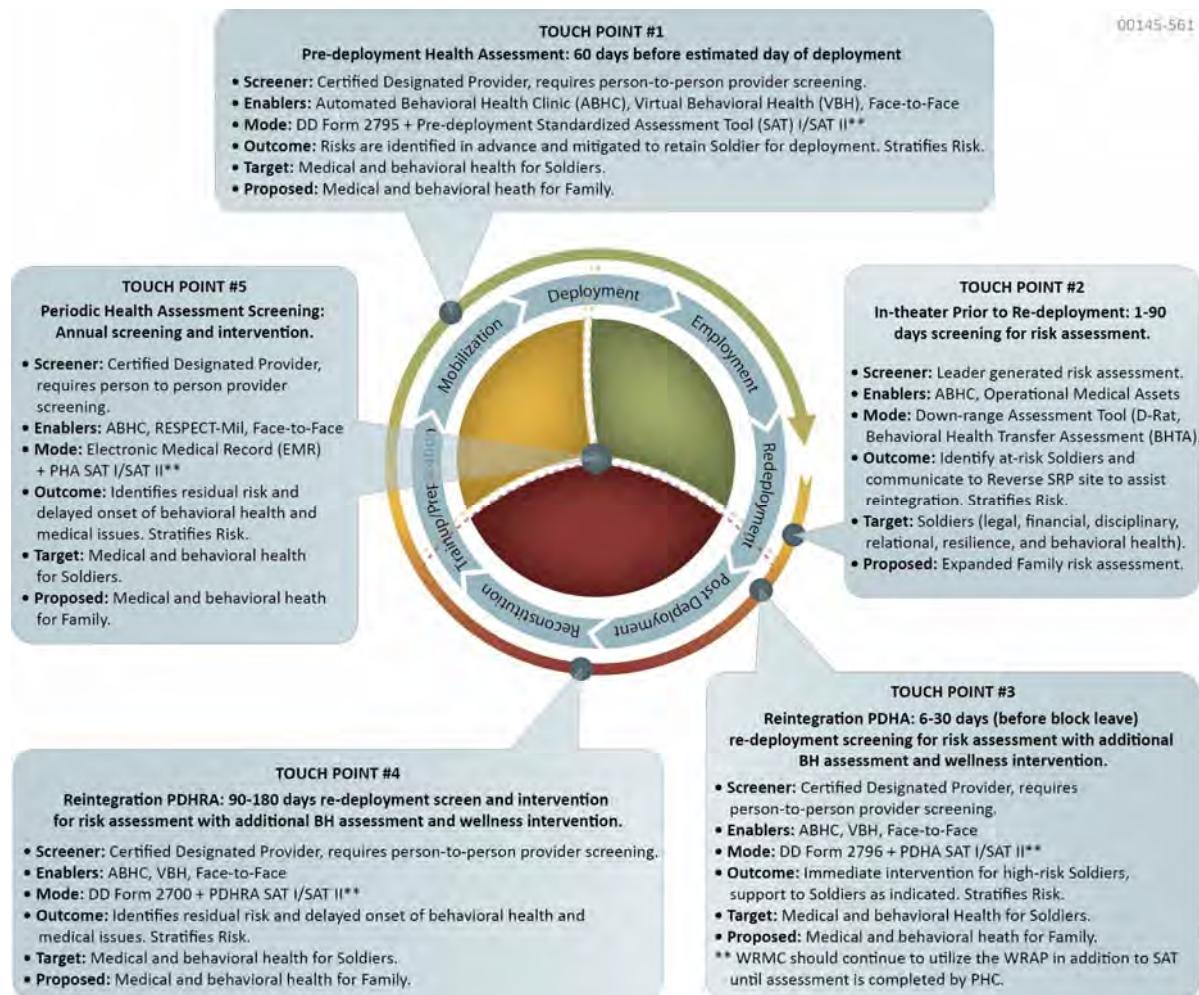


Figure II-4: Behavioral Healthcare Touch Points¹³

MEDCOM's campaign has been aggressive to say the least. Through March 2011 it has published seven additional fragmentary orders (FRAGO) since the original publication of the campaign plan in September 2010, providing additional implementing guidance and synchronization. A review of these FRAGOs can be generally summarized in several key developmental areas. First, they outline the transition of care for Soldiers transferring from program to program during PCS. Second, they standardize and synchronize tele-health procedures and requirements to optimize behavioral healthcare services and resources. Third, they outline a care provider support program to reduce care provider fatigue. Fourth, they expand embedded behavioral health providers at brigade combat team (BCT) stations to improve pre-, during, and post-deployment behavioral healthcare. Fifth, they provide guidance for collecting campaign metrics. Finally, they task primary care providers to conduct face-to-face screens for available Soldiers and virtual screens for geographically dispersed Soldiers. This campaign plan and subsequent FRAGOs exemplify the Army's commitment to improving behavioral health across the Army ahead of the strategic reset.

LEARNING POINTS

- ★ All leaders recognize and are executing MEDCOM's *Comprehensive Behavioral Health System of Care* which identifies, prevents, treats and tracks behavioral health conditions during the ARFORGEN cycle (figure II-4).

2. Medical Issues

a. mTBI

Over the last few years, the Army has made vast improvements in understanding and countering the effects of mTBI (also known as “concussion”). We understand, for instance, more about the dichotomy of brain and mind. Physical injuries from concussive events can affect both the brain, as a physical injury, and the mind, as a psychological injury. Physical injuries to the brain can be more readily identifiable with more obvious implications on health and well-being, while injuries to the mind (or invisible wounds) can be harder to detect and diagnose. Research from UCLA, and other academic institutions, is informing occupations and activities that pose potential risks associated with concussive brain injuries, particularly among military and sports occupations.

The pictures at figure II-5 illustrate three separate brain activity images: post-concussion (commonly known as getting your “bell rung”), after a severe traumatic brain injury (resulting in coma) and a normal healthy brain. The more vibrant red and yellow colors represent higher brain activity levels, indicated in the image on the right of a normal male undergraduate student at UCLA. The darker blue color in the images at center and left reflect areas in two separate brains that are less active or at rest. While they depict similar brain activity levels, they represent two separate patients under very different conditions. The picture at center is an image taken from a traumatic brain-injured patient who sustained a severe head injury in a serious car accident. The positron emission tomography (PET) scan was taken five days after the accident while the patient was still in a coma and unresponsive. The image at left is that of a UCLA football player 24 hours after he received a concussion during a game. He never lost consciousness, was cleared to continue to play by sideline medical staff, and at the time of the PET scan was awake, fully able to talk, walk and only had mild symptoms from the concussion. Both images, one taken after a severe trauma and the other after a mild concussion, depict similar brain activity levels. It seems that both brains, despite differences in the severity of injury and subsequent patient function, have equally reduced activity—likely a reflection of the need for rest and recovery.¹⁵

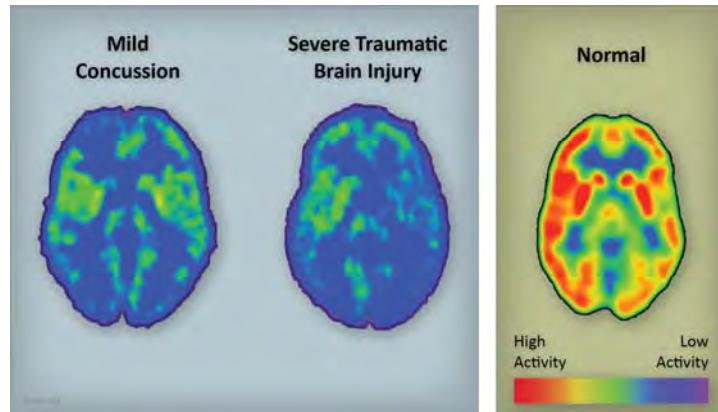


Figure II-5: Brain Images¹⁴

An important lesson for Army leaders can be found in examining and comparing the latter two brain injury events. Successful surveillance and detection of concussive injuries often occur based on loss of consciousness, retrograde amnesia (memory loss) or other indications of brain dysfunction. However, it is important to note that the UCLA football player, similar to many combat-related concussive injuries, passed initial screenings by medical staff for a concussive injury despite the fact that his PET scan mirrors that of someone in a coma. Nevertheless, his lack of obvious symptoms does not reduce the risk associated with a second concussive injury before the first one has healed. This highlights the importance of surveillance and detection of potential brain injuries following combat-related concussive events.

VIGNETTE— NFL BRAIN TRAUMA

Professional football player Dave Duerson retired from the National Football League in 1993. Following his retirement, he became successful in the food-service industry. In time, unfortunately, he began experiencing "...symptoms of repetitive brain trauma, including memory loss, poor impulse control and abusive behavior towards loved ones." Soon his marriage failed, his business collapsed and he filed for bankruptcy. In the months leading up to his death he stressed his failing mental health to his family. In his final note to his family, he wrote, "Please see that my brain is given to the NFL's brain bank." Dave committed suicide on 17 February 2011. It is believed that he shot himself in the chest to preserve his brain so that it could be examined by Boston University's Center for the Study of Traumatic Encephalopathy. An examination of his brain revealed that he had developed trauma-induced disease, known as chronic traumatic encephalopathy (CTE). The same disease was recently found in 24 other deceased NFL players. Dave's son Brock stated during an interview, "I don't want people to think just because he was in debt and broke he wanted to end it. CTE took his life. He changed dramatically, but it was eating at his brain. He didn't know how to fight it."¹⁶

LEARNING POINTS

- ★ Surveillance and detection of potential brain injuries following combat-related concussive events are critical to reducing the impact on Soldier health and readiness.
- ★ A lack of obvious symptoms does not reduce the risk associated with a second concussive injury before the first one has healed.

(1) mTBI (Concussion) is a National Issue

Improvements in science have inspired traumatic brain injury (TBI) prevention and treatment nationally along occupational lines, with military and sports medicine, among others, at the forefront of research, diagnosis, treatment and increasing community awareness. In the area of sports medicine, youth sports programs have made sweeping changes regarding mTBI management. For example, on July 26, 2009, Washington State passed the Zackery Lystedt Law, which requires school sports programs to manage concussion and head injuries associated with youth sports.¹⁷ Additionally, legislation was introduced into Congress in January 2011 to aid schools in managing concussion-related injuries. Over the last two years 29 states have enacted concussion or "return-to-play laws" with 13 additional states pending final legislation. This movement has also expanded to professional and college sports programs as mTBI-type injuries continue to proliferate across a wide variety of contact sports.¹⁸

The Idaho State University Athletic Program provides an excellent example of a growing awareness of sports-related concussions in its *Fall 2011 Newsletter: Get Current on Concussion, Identification and Management Strategies for Coaches, Parents, Athletes & Medical Practitioners*.¹⁹ The newsletter highlights that "Concussion is more than an injury, it is a silent killer." It provides some sobering facts including: ~300,000 sports related concussions in the US annually; 1/3 involve high school football; 60% of all teenage athletes will experience a concussive injury with thousands going unreported; and that concussion-related brain injuries are second only to injuries related to motor vehicle accidents for young people ages 15-24. Although it highlights that concussions are still largely misunderstood and misdiagnosed after two decades, it warns that "Postconcussive Syndrome [PCS] can last for weeks, months or years after a concussion." It follows with a dire warning that a second concussion before the first has healed can lead to rapid brain swelling with "little hope of recovery."

Beyond awareness, it recommends diagnostic testing to include: Standard Assessment of Concussion (SAC), Balance Error Scoring System (BESS) and neuro-cognitive software-based assessments such as ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing). It recommends that diagnosis is followed by a six-step return-to-play protocol to gradually integrate the athlete back into play. Although this information provides an example of sports-related concussions, mTBI-related injuries cut across national activities / incidents associated with head trauma (e.g., occupational hazards, vehicle accidents, aggravated assaults and other blunt-force trauma).

VIGNETTE— IDAHO STATE HIGH SCHOOL SENIOR FOOTBALL PLAYER

“Kort Breckenridge continued to play football while still suffering the effects of a previous concussion. He hid his symptoms from his parents and coaches. After a routine tackle, he struggled to stand. He was pulled from the game. Within minutes he was seizing violently, then went unconscious and nonresponsive. He was transported to a hospital. The entire right side of his brain was removed. He was in an induced coma for two weeks. He remained in the hospital for the next three months. Today Kort continues therapy. His speech is slurred, walks with a limp, tires easily, has difficulty staying on task, and his short-term memory is nearly non-existent. He will remain this way, most likely, for the rest of his life.”²⁰

(2) Impact of TBI on the Force

“Traumatic Brain Injury can be caused by bullets or shrapnel hitting the head or neck, but also by the blast from mortar attacks or roadside bombs. Closed head wounds from blasts, which can damage the brain without leaving an external mark, [were] especially prevalent in Iraq. About 68% of the more than 33,000 wounded in action [during OEF / OIF] experienced blast-related injuries.”²¹

TBI has had a profound and measurable physical and behavioral health impact on the Force, widely affecting Army Soldiers and Families, unit readiness, and Soldiers in transition to civilian life. It causes both physical and psychological impairment and can be difficult for leaders and medical staff to detect. It is classified as mild, moderate and severe, with the term “mild” used interchangeably with mTBI and concussion.

While this classification describes severity of injury to

the brain and does strongly predict the level of subsequent impairment, it does not perfectly predict who will fully recover from injury. Most individuals recover rapidly after concussions, although a small percentage goes on to experience more lasting symptoms. The biggest concern in concussion treatment is ignoring treatment right after the concussion occurs, when the brain needs time to heal. It is vitally important to prevent a second concussion too close to the first one, as back-to-back concussions (including mild concussions) can lead to severe brain damage, and in rare cases, death.

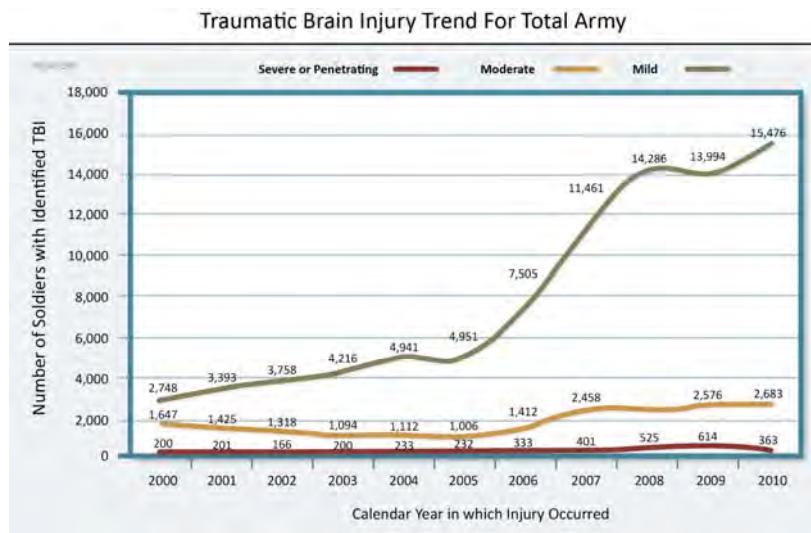


Figure II-6: Impact of TBI on the Force²²

The total Army has had over 126,545 diagnosed cases of TBI between CY2000 and CY2010 (figure II-6). Severity includes 95,251 mTBI, 20,149 moderate and 3,571 severe / penetrating injuries, though there are a number of additional concussions that go untreated.²³ Milder effects of TBI on individual Soldiers include impaired memory, concentration, reaction time, balance problems, impaired vision, headaches and sleep disruption. More serious effects of moderate and severe TBIs include coma and, in extreme cases, death. Most Soldiers with TBI—especially those with mTBI—fully recover.

LEARNING POINTS

- ★ Most concussions heal; however, some can result in persistent symptoms that can cause emotional, behavioral and cognitive symptoms and reduce Soldier performance and readiness.

(3) DoD mTBI Protocols

Post-blast mTBI research has shed new light on the importance of rapid medical evaluation following a potential concussive event. DoD developed mTBI protocols in 2010 to enhance early detection and intervention following concussive events in combat, but are equally relevant to traumatic head injuries from non-combat related accidents.²⁴ mTBI protocols are required to be implemented during in-theater post-blast, overpressure, and other concussive exposure events (e.g., vehicle rollover, fall or sports injury). Commanders or their representatives are required to ensure that all Servicemembers involved in a “mandatory event,” including those without apparent injuries, are medically evaluated as soon as possible using the Injury / Evaluation / Distance from Blast (I.E.D.) checklist.²⁵ Mandatory events include:

- Any [Soldier] in a vehicle associated with a blast event, collision, or rollover;
- Any [Soldier] within a specified distance (actual distance is FOUO) of a blast (inside or outside);
- A direct blow to the head or witnessed loss of consciousness;
- Command-directed, especially in a case with exposure to multiple blast events.

Additionally, DoD published evaluation criteria following a mandatory event to provide guidance for medical evaluations and referrals. Evaluation periods are adjusted for each recurrent event starting with the first event, with a mandatory minimum of 24-hours, and then adjusting the period for each subsequent event. The evaluation criteria are designed to prompt referrals for medical evaluations based on Soldiers demonstrating any symptoms catalogued under the acronym “H.E.A.D.S.”:²⁶

- H – Headaches and / or vomiting
- E – Ears ringing
- A – Amnesia and / or altered consciousness and / or loss of consciousness
- D – Double vision and / or dizziness
- S – Something feels wrong or is not right

LEARNING POINTS

- ★ “Mandatory Events” refer to events associated with potential head trauma that require Soldiers to be screened using the I.E.D. and H.E.A.D.S checklists for potential medical evaluation.

(4) The Army's mTBI Campaign Plan

The Army's mTBI Campaign Plan, *Warrior Concussion and mild Traumatic Brain Injury (mTBI) Campaign Plan*, was published in June 2011 well after the Army had begun implementing DoD mTBI protocols. It is comprised of three phases: (1) Development— which identified program requirements; (2) Implementation— which focused on integration of policy and resource solutions; and (3) Full Execution, Assessment and Improvement—which focuses on changing the culture across the Army that recognizes concussion / mTBI as a physical injury which must be identified, treated and tracked appropriately.

The campaign plan sets a serious tone under the “Situation” paragraph, which states “...the effects of concussion / mTBI can have lifelong impacts on our Soldiers if persistent symptoms are left untreated. The intent of this campaign is to take a strategic approach... [as] the optimal means of reversing the lack of understanding, identification, and treatment of concussion / mTBI.”²⁷ The campaign is designed to educate, train, treat and track mTBI across the Force. To this end, it has incorporated mTBI education into professional military education (PME) to increase leader understanding of mTBI as a real physical injury with appreciation for how it may present without obvious physical symptoms or as an “invisible wound.” Additionally, the Army is increasing mTBI training through the publication of DoD’s mTBI protocols in FORSCOM’s *Pre-Deployment Training Guidance*, which mandates mTBI protocol training for all deploying units.²⁸

(5) TBI Effects on the Soldier and Family

VIGNETTE—THE EFFECTS OF TRAUMATIC BRAIN INJURY

(Academy Award winner Forrest Whitaker reciting the words of a SPC who sustained a severe brain injury in an IED explosion) “The bomb blasted thru the windshield right to my face, vehicle flipped three times, and an M-16 rifle smashed right into my skull. It was lights out. My brain, my mind...right away I noticed things weren’t the same. The simplest things like putting on a seat belt is frustrating. Short term memory is gone. The Army was my life, it’s all I ever wanted to do. I’m not gonna quit, for my kids, for my wife. It’s been seven years since that IED blasted my vehicle, my brain. The only thing I can do is take it one day at a time for the rest of my life.”²⁹

We only need to summarize the symptoms of TBI to grasp the many challenges confronting Soldiers and Family members impacted by diagnosed and undiagnosed TBI. Any one or a combination of TBI symptoms will seriously affect Soldiers and Families. These symptoms can degrade daily activities and, even if only temporary, can have a more lasting effect on social and familial relationships, work production and unit / team readiness.

Symptoms can also exacerbate other psychological and behavioral issues, in effect snowballing from one manifestation to others (especially in cases of undiagnosed mTBI). For instance, frustration from any one of the symptoms mentioned earlier can transfer to anger which can lead to domestic disturbances or work-related problems. Even with proper diagnosis and treatment of mTBI, a small percentage (10-15%) of mTBI cases may develop chronic and potentially disabling post-concussive symptoms.³⁰ At the other end of the spectrum, moderate and severe TBI can have long-lasting and frequently permanent effects. Like many health issues, volumes can be written on the effects of TBI on Soldiers and Families, but perhaps no more eloquently than described in SPC’s testimonial below.

(6) mTBI Policy and Programs

The Army's progress in identifying mTBI risk factors and promoting diagnosis and treatment continues to reduce the effects of both combat and non-combat brain injuries. The Army has established and implemented effective policy, programs and protocols since the publication of DoD's Directive-Type Memorandum (DTM) 09-033, *Policy Guidance for Management of Concussion / Mild Traumatic Brain Injury in the Deployed Setting*, and continues to increase mTBI awareness through a campaign plan emphasizing four lines of effort: education, training, treatment and tracking. The goal of mTBI policy is to expedite evaluation and treatment following a blast, concussive or overpressure exposure event and improve training, identification, treatment, reporting and tracking.

The effects of these policies are particularly evident in the implementation of down-range protocols that have temporarily removed over 9,000 Soldiers from combat operations for evaluation and medical referral in the last year. This has allowed Soldiers a critical window of time to rest and recover from potential brain injuries, as well reducing the risks associated with the effects of mTBI on continued service under combat conditions. Soldiers who in previous years would have pressed on while suffering some level of cognitive impairment are now temporarily sidelined for evaluation and potential treatment. It goes without saying that Soldiers who continue to operate in combat with symptoms such as reduced reaction time, impaired vision or impaired hand-eye coordination invariably place themselves and others at greater risk. These protocols provide Soldiers who experience potential concussive events necessary down time and, given the vast majority who are returned to combat, add additional protective measures with no cost to unit readiness.

The fact that the Army has diagnosed and treated over 126,000 cases of TBI since the beginning of the war indicates that Army leaders take TBI seriously. Indeed, the investment in terms of resources to treat and track this number of Soldier injuries demonstrates an unprecedented commitment to reducing the risk associated with invisible wounds. And the Army continues to learn. Of the 126,000 cases of TBI, 54% were diagnosed in the last four years. The Army implemented mTBI protocols only ~18 months ago with the 101st Airborne Division, published the mTBI Campaign Plan in June 2011 and established mTBI pre-deployment training in FORSCOM's *Pre-Deployment Training Guidance*. As a result of these proactive measures, the Army diagnosed over 1,400 cases of mTBI in Iraq and Afghanistan from August 2010 to June 2011.³¹ These diagnoses not only confirm the successful implementation of the mTBI campaign plan, but also the successful collaboration between the health triad of commander, health provider and Soldier. This is particularly impressive in that it occurred while in the complex environment and high OPTEMPO of combat operations.

LEARNING POINTS

- ★ The goal of mTBI policy is to expedite evaluation and treatment following a blast, concussive or overpressure exposure event and improve training, identification, treatment, reporting and tracking.
- ★ Soldiers who continue to operate in combat with symptoms such as reduced reaction time, impaired vision and sleep deprivation invariably place themselves and others at greater risk.
- ★ mTBI protocols emplace additional protective health measures with no cost to unit readiness.

b. Post Traumatic Stress (PTS) and Post Traumatic Stress Disorder (PTSD)



“Anybody that’s been to the gates of Hell has PTS. It’s something you have to remind yourself of if you find yourself drinking too much, snapping at your kids, snapping at your wife. Go seek help. It took me 30 years to do so. Look for it now, and most important, stay sober.”³²

—CPT (Ret.) Paul “Bud” Bucha
Medal of Honor Recipient
June 2010

Post traumatic stress (PTS) and its associated disorder (PTSD) are important health concerns for Soldiers and the Army as a whole. PTSD lacks the clear physical trauma that would otherwise hasten detection and diagnosis. Old as battle itself, its formal recognition comes late in modern warfare. Previously referred to as “shell shock” or “battle fatigue syndrome,” the condition was not formally recognized as PTSD until it was added to the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) in 1980.³³ Its lack of clear physical or biological markers and shared symptomology with other disorders may explain much of the controversy over its diagnostic criteria as noted in literature spanning the decades since its formal recognition.³⁴

PTSD is defined based on three sets of symptoms: “re-experiencing (experiencing nightmares, being distracted by intrusive deployment-related memories), avoidance or emotional detachment (e.g., avoiding doing things that were previously enjoyable because they remind Soldiers of combat, such as going out to a crowded mall or movie theater), and physiological hyperarousal (feeling constantly on edge or hyperalert, having difficulty sleeping, feeling a lot of anger, having concentration or memory problems). There may also be guilt or a strong urge to use alcohol or drugs (“self-medication”) to try to get sleep or not think about things that happened downrange.” These symptoms must persist for at least 30 days and impair function to some degree to reach clinical disorder thresholds.³⁵

Combat is not the only traumatic stressor that can predispose a Soldier to PTSD (e.g. accidents, injuries in garrison, assaults, traumatic events prior to entering service, etc.). This is consistent with research which found that among a population of 60,000 Afghanistan and Iraq era veterans diagnosed with PTSD between 2003 and January 2011, 7,624 had never deployed.³⁶ This dichotomy was also found among Vietnam veterans, which placed the prevalence of PTSD at “...over 30% for all those who had served in the military, even though only 15% of those were actually assigned to combat.”³⁷ It is important to note, however, that approximately 5% of the US population meets PTSD criteria, largely due to childhood trauma. These individuals will enter military service having already experienced trauma as a child. This may largely explain the incidence of non-combat related PTSD among veterans.³⁸

(1) The PTSD Epidemic

Recent literature on PTSD has broadly scoped the population of Iraq and Afghanistan veterans suffering from PTSD. The numbers are alarming. A 2008 projection estimated that there were 300,000 veterans with PTSD from these two theaters alone with an estimated cost of care ranging between \$4 and \$6.2 billion by early 2010.³⁹ Subsequent research in 2010 places this number even higher, estimating that approximately 20% (or more) of over two million Servicemembers who deployed will develop PTSD.⁴⁰ This may ultimately place the PTSD population closer to 472,000 for all

Servicemembers or 236,000 Soldiers as of September 2011.¹ These estimates and projections parallel data provided by VA, which reported that 187,133 Iraq and Afghanistan veterans were diagnosed with PTSD by mid-2011.⁴¹

(2) PTSD Rates among Veterans

Analyses of PTSD in Vietnam veterans provide some insights into future PTSD among Iraq and Afghanistan veterans. Although there has been much debate regarding actual numbers of Vietnam veterans suffering from PTSD, the most recent comprehensive study using the most refined case definitions indicates that 9.1% of Vietnam veterans currently suffer from PTSD and 17.8% develop PTSD sometime during their lifetime.⁴² Combat frequency and intensity were shown to be a strong predictor, with rates of PTSD ranging between 25-30% among Vietnam veterans who experienced the highest levels of combat exposure. These rates are very consistent with what has been observed so far in the OEF / OIF wars.⁴³ Literature reviews also characterize PTSD as a long-term disorder, with a significant impact on functioning.⁴⁴ This is supported by studies among aging WWII and Korea veterans that showed that “stressful life events” (e.g., loss of loved ones) trigger late onset of PTSD or a recurrence of dormant PTSD.^{45,46}

These cross-generational findings provide lessons for the management of PTSD in the current generation of Iraq and Afghanistan veterans, who are also experiencing stressful life events. First, consideration must be given to ongoing life stressors that may heighten PTSD symptoms among contemporary veterans. Second, differences between these cohorts demonstrate that “Iraq and Afghanistan veterans were less often diagnosed [and treated for] substance abuse disorders, manifested more violent behavior, and had lower rates of VA disability compensation because of PTSD.”⁴⁷ Although the latter may be ameliorated by recent changes in VA benefits as discussed below, current treatment of Iraq and Afghanistan veterans should take into consideration the potential for manifestations of substance abuse and violent behavior as well as the potential for recurrence or late onset of PTSD.

An interesting finding that demonstrates promise for early intervention revealed that active social engagement can reduce the onset and severity of PTSD symptoms. Multiple studies have demonstrated the importance of strong social support (e.g., family, friends, co-workers) in the recovery from this condition. One study, for instance, found that “Vietnam veterans who report active engagement in the community are less likely to have PTSD.”⁴⁸ Social therapy or “[a] tendency to use social support [systems] specifically to disclose personal problems and to talk about events experienced during a deployment are also associated with adjustment. For example, Vietnam veterans who discussed their military experiences demonstrated decreased rates of PTSD.”⁴⁹ Similarly, other studies found “that a lack of family cohesion predicted the development of PTSD in Persian Gulf veterans.”⁵⁰

The relationship between a lack of ongoing cohesion after return and PTSD may explain why Army health assessments found that 20% of returning RC Soldiers, as compared to 11% of Active Component (AC) Soldiers, reported two or more PTSD symptoms 3-6 months post deployment.⁵¹ This may not be surprising given the loss of team cohesion and geographical dispersion of RC Soldiers following redeployment and demobilization. It may also have been partially due to the limited six month window for TRICARE following transition, which was recently lengthened to two years. Regardless, the relative social cohesion among the majority of redeploying veterans today, likely an outcome of the Army’s

¹ PTSD projection is calculated using the 20% estimate provided by research against the 30 Sept 2011 DMDC data (~2.3 million Servicemembers and ~1.2 million Soldiers have deployed since 2001).

focus on unit reintegration and reset, may set conditions for the observation that “[t]here is a window of opportunity...for developing and focusing on treatment interventions that emphasize the preservation of these social assets.”⁵²

LEARNING POINTS

- ❖ A holistic approach to PTSD treatment should consider the potential for manifestations of substance abuse and violent behavior as well as the potential for its recurrence or late onset.

(3) The Impact of PTSD on the Force

PTSD has a far-reaching impact on the health of the Force. The most obvious impact of PTSD on the Force involves the sheer number of Soldiers presenting PTSD and PTS-related symptoms, the resulting pressure on the medical and disability evaluation systems and, ultimately, the aggregate impact on Soldier and unit readiness. For instance, “PTSD was significantly associated with lower ratings of general health, more sick call visits, more missed workdays, more physical symptoms, and high somatic [physical] symptom severity.”⁵³ Soldiers experiencing hallmark PTSD symptoms (re-experiencing, hyperarousal and avoidance) will almost certainly experience impaired social functioning, which may adversely impact Soldier / team performance, particularly in the high-stress occupation and environment associated with military service. Moreover, Soldiers with PTSD may continue to be more susceptible to episodic recurrences of severe symptoms based on stressful events associated with military life (e.g. deployments, extended family separations, and continued high OPTEMPO).

Increased rates of PTSD may also be associated with repetitive deployments and short dwell time. Research on diagnosed veterans indicate that the cumulative effect of deployments—and presumably combat—may increase the risk for PTSD. The September 2011 Medical Surveillance Monthly Report found that “larger percentages of males were diagnosed with PTSD after second through fourth deployments, and with adjustment reactions, anxiety-related disorders, and depressive disorders after second and third deployments, than after first deployment.”⁵⁴ Medical Health Advisory Team (MHAT) data has shown that shorter dwell time is associated with increased risk of PTSD symptoms. These data indicate that there is a cumulative strain from multiple deployments and short dwell time, and that the rest between deployments for many units does not appear to be adequate. The Army’s goal to decrease deployments from 12 to 9 months after February 2012 and its goal to increase Boots on the Ground (BOG):Dwell to 1:3 should have an impactful effect in reducing deployment related stress.

A particularly disturbing difficulty among Soldiers with PTSD is the co-existence of other problems, such as aggression towards a spouse or partner. Two studies covering Vietnam veterans in 2007 and 2009 found that aggression was more prevalent among veterans with PTSD than those without PTSD.^{55,56} The latter study more specifically found (from a population of 1,632 Vietnam veterans) “...that the rates of aggression for men and women were 41% and 32%, respectively, and men appeared to perpetrate relatively more acts of severe aggression.”⁵⁷ A subsequent study in 2010 of Iraq and Afghanistan veterans determined that male veterans with PTSD were 1.9-3.1 times more likely to demonstrate aggression toward their female partners.⁵⁸ And, in particular, PTSD-related hyperarousal (PTSD symptom) seems to lead to higher levels of partner aggression.⁵⁹ This would imply that Soldiers with PTSD may have one foot in each camp, raising both health and disciplinary considerations for treatment / prevention and Soldier accountability. The following scenario highlights the potential seriousness of PTSD-related aggression:

VIGNETTE— IMPACT OF PTSD, ALCOHOL AND ILLICIT PRESCRIPTION DRUGS

A 24-year-old SPC had recently returned from his second combat deployment. He suffered from severe PTSD and alcoholism. On 26 March 2011, while on terminal leave, he was discussing his military experiences with two civilians when he became involved in a verbal altercation. The incident escalated and he shot both of them. Shortly after fleeing the scene he became involved in a shoot-out with police before turning the gun on himself. A post-mortem toxicology report reflected the presence of three benzodiazepines (anti-anxiety) medications including Nordazepam, Temazepam and Oxazepam at the time of his death. His medical records revealed the SPC was not prescribed these medications.

This single incident depicts a scenario in which a Soldier, who is suffering from PTSD and substance dependence, perhaps suffering from stress associated with his transition from the Army, acts out violently before taking his own life.

(4) Reducing Stigma Associated with PTSD

The Army has taken conscious steps to adjust policy to reduce stigma associated with behavioral healthcare. However, change must occur within the broader perspective of national culture and policy. For instance, as GEN Chiarelli indicated in a November 2011 interview, PTSD continues to carry a stigma, especially amongst young Soldiers. According to GEN Chiarelli, “There is a stigma attached to any mental illness...to convincing a 19-year-old Soldier who thinks he’s invincible that he’s got an issue...a no kidding injury that he can’t see and that many of his buddies don’t even believe is real.” For this reason, GEN Chiarelli (among others) has advocated to change the “D” from “Disorder” in PTSD to “I” for “Injury,” to dispel the perception that the word “disorder” reflects an individual weakness.⁶⁰ Use of the term “injury”, on the other hand, more accurately characterizes the trauma associated with this condition. This change, however, will require close collaboration with national medical organizations (e.g., American Psychiatric Association) to assess the impact of diagnoses of mental illness on help-seeking behavior, treatment and care. In this example, change to policy could reverse over 40 years (since Vietnam) of stigma associated with combat-related PTS “I” among America’s veteran population.

LEARNING POINTS

- ★ The Army’s goal to decrease deployments from 12 to 9 months in 2012 and its goal to increase BOG:Dwell to 1:3 should have a beneficial effect in reducing deployment-related stress. As the Army increases its dwell time, it may see an increase in behavioral healthcare contacts and therefore, an increase in diagnoses.
- ★ PTSD-related aggression may infer that Soldiers have one foot in each camp, raising both health and disciplinary considerations for treatment / prevention and Soldier accountability.
- ★ Many advocate changing the “D” in PTSD from “Disorder” to “I” for “Injury,” to dispel the perception that the word “disorder” reflects an individual weakness. Use of the term “injury” more accurately characterizes the trauma associated with this condition.

(5) PTSD Policy and Programs

The Department of Veterans Affairs eased policy for determining disability benefits for PTSD in July 2010. The new policy widened the aperture for PTSD compensation by removing requirements to document specific combat-related events such as IED exposure, combat engagements and other combat-associated traumatic events. This change in policy will lessen the burden for combat veterans

seeking PTSD disability benefits and treatment unrelated to direct combat operations. It also will “...allow compensation for Servicemembers who had good reason to fear traumatic events, even if they did not actually experience them.”⁶¹ This policy is more in tune with the realities of service-related PTSD and supported by research findings that are increasingly identifying a population of veterans who are reporting PTS-related symptoms associated with general wartime service, rather than service specific to combat operations. It is a good news story that recognizes that Soldiers who did not serve in direct combat operations may develop PTSD. This policy, more than any other, recognizes the prolonged and cumulative impact of PTSD on the lives of veterans.

The Army continues to improve its surveillance, detection and response programs / services to reduce the effects of PTSD on service and post-service veteran health. From a unit perspective, leader emphasis on redeployment reintegration and Soldier-civilian transition is critical to early diagnosis, treatment and follow-up care. Enhancing or preserving the social network of Soldiers at risk for PTSD is a key aspect of reintegration and should emphasize social and family engagement prior to and during Soldier transitions and ongoing treatment. Leaders at all levels must increase awareness of changes in behavior that may indicate a general decline in mental and physical health. The latter highlights an increased understanding regarding the relationship between physical and psychological injuries, underpinned by the research conclusion that “[c]ombat veterans with serious somatic concerns [physical symptoms] should be evaluated for PTSD.”⁶²

Increased social support is important among veterans of all wars with PTSD or PTS symptoms. This is a critical element in Comprehensive Soldier Fitness (CSF) efforts to enhance post-traumatic growth. It is also likely that increased social support may also increase social acceptance, which has been shown to be a predictor for successful PTSD mitigation among returning veterans.⁶³ Also, therapy linked to social support through buddy or peer-to-peer involvement has found success in increasing behavioral health treatment-seeking among returning veterans.⁶⁴

Finally, tele-health is proving to be an effective medium in delivering a wide range of behavioral health therapies targeting PTSD among geographically isolated or dispersed Soldiers such as Army National Guard and US Army Reserve (USAR) Soldiers. For example “[e]xposure therapy delivered via tele-health was effective in reducing the symptoms of PTSD, anxiety, depression, stress, and general [cognitive] impairment...”⁶⁵ Evidence indicates that clinical encounters delivered via tele-health generally have similar levels of patient satisfaction and effectiveness as face-to-face visits, and are therefore acceptable ways to deliver care according to the latest PTSD DoD-VA Clinical Practice Guidelines, with particular benefits expected for delivering therapies to geographically dispersed locations.⁶⁶

LEARNING POINTS

- ❖ In some respects PTSD reflects natural physiological processes that serve to protect Soldiers in combat (e.g., hyper-vigilance, avoidance).⁶⁷
- ❖ A change in VA policy has lessened the burden for combat veterans seeking PTSD disability benefits and treatment for experiences unrelated to direct combat operations.
- ❖ Leader emphasis on redeployment reintegration and Soldier-civilian transition is critical to early PTSD diagnosis, treatment and follow-up care.
- ❖ Enhancing or preserving the social network of Soldiers at risk for PTSD is a key aspect of unit reintegration and should emphasize social and family engagement during transitions.

★ Tele-health is proving to be effective in delivering a wide range of behavioral health therapies targeting PTSD among geographically isolated or dispersed Soldiers (ARNG / USAR).

c. Depression

Major depression (or major depressive disorder) is generally the most prevalent of mood disorders affecting the US population today, effecting approximately 7-10% of all Americans. In CY2005 and CY2006, an annual average of 15.8 million adults aged 18 or older (7.3%) experienced a major depressive episode (MDE) in the past year.⁶⁸ This is consistent with research by the National Institute of Mental Health (NIMH) which found in a 2005 national survey that 9.5% of the US adult population self reported suffering from mood disorders, including major, mild and manic depression.⁶⁹ The economic impact of depression affects national productivity and has been reported to be one of the most "...expensive mental disorders, costing the United States an estimated \$66 billion per year."⁷⁰

(1) Impact of Depression on the Force

VIGNETTE— COMORBIDITY'S LETHAL IMPACT

A 40-year-old SPC who had entered the Army at 35 and had deployed once, had a history of PTSD, major depression, insomnia, adjustment disorder and suicide ideation. Also, his spouse was divorcing him due to an extra-marital relationship. Unit leadership indicated that the SPC had been seen several times under emergency conditions for his behavioral health issues. They had identified him as a high-risk Soldier and monitored him in case he needed help. Regardless, things started to spiral as he increasingly engaged in high-risk behavior. On 15 May 2011, he allegedly sexually assaulted and forcibly sodomized a PFC while she was in bed, incapacitated from alcohol. Four days later, his spouse served him with a Domestic Violence Protective Order. He was subsequently referred and enrolled into inpatient behavioral healthcare with a law enforcement interview scheduled for the sexual assault pending his release. On 25 July 2011, he was found dead under a picnic table with a self-inflicted gunshot wound to the head. The local coroner did not submit toxicology samples, so use of drugs and alcohol remain unknown.

This scenario represents a Soldier who was in almost every concentric ring of the Maze before spiraling to its center: he suffered from behavioral health issues, was taking medication, allegedly committed a felony crime, was the subject of an active investigation, exhibited suicidal ideation, (additionally, had family / marital problems) and ultimately committed suicide.

A large study of 206,000 veterans (using VA health records from 2000-2007) determined that “one in three patients was diagnosed with at least one mental health disorder – 41 percent were diagnosed with either a mental health or a behavioral adjustment disorder,” with 14% diagnosed with depression. The same study noted that depression is typically under-diagnosed among veterans.⁷¹ Reported depression among Soldiers can be attributed at least in part to deployments with “~32% of Soldiers report[ing] depression symptoms 3-6 months post deployment.”⁷² This is consistent with research from the Institute of Medicine that found recurring deployments increased the prevalence of mental health issues among returning Soldiers. It concluded that “27% of those who deployed 3-4 times received diagnoses of depression, anxiety or acute stress compared to 12% of those deployed just once.”⁷³ Given the fact that the Army currently has 124,576 Soldiers with 3-4 deployments (i.e., AC-91,998; ARNG-17,061; USAR-15,517), it is likely that as many as 33,636 Soldiers are suffering from diagnosed or undiagnosed depression, anxiety or acute stress.⁷⁴ Although the cost of depression among active duty

(AD) Soldiers has not been calculated, based on veteran care for depression (estimated at over \$9 billion annually) it is assumed to be substantial.⁷⁵

(2) Depression Associated with Other Behavioral Health Issues

Major depression among Soldiers often occurs with other physical and behavioral health issues including TBI, PTSD and anxiety as discussed under *Comorbidity* (Chapter II, Section 3.a.). As such, depression can complicate surveillance and detection of other physical or behavioral health issues that coincide with its occurrence. Both diagnosed and undiagnosed depression can increase the risk associated with other at-risk outcomes such as suicide and partner aggression. Those among the US population "... with lifelong history of major depression were 10 times as likely to report having thoughts of suicide."⁷⁶ Additionally, in one study the "presence of depressive symptoms was positively associated with the presence and severity of domestic violence....for each 20% increase in depressive symptoms, there was a 74% increase in the likelihood of husband-to-wife aggression"; this positive correlation was also found among Vietnam veterans.⁷⁷

Substance abuse has also been linked to depression and PTSD. One study found that individuals suffering from depression "were approximately twice as likely to have a co-occurring substance use disorder." The same study reported that 20-67% of the people who sought alcohol treatment had experienced depression. The report explained that "mood disorders may motivate individuals to resort to drugs and alcohol to cope" with their symptoms. It goes on to explain that "[t]he substances may initially minimize or moderate the mood symptoms, but withdrawal and chronic abuse typically exacerbate mood degradation, leading to increasing abuse and ultimately dependence." Given the association of alcohol and drug use with mood disorders and particularly depression, Soldiers being treated for either should be evaluated for the other.⁷⁸

LEARNING POINTS

- ★ Given the association of alcohol and drug use with mood disorders and particularly depression, Soldiers being treated for either should be evaluated for the other.
- ★ Research found that the "presence of depressive symptoms was positively associated with the presence and severity of domestic violence...for each 20% increase in depressive symptoms, there was a 74% increase in the likelihood of husband-to-wife aggression."

d. Drug and Alcohol Abuse

Drug and alcohol abuse is a good example of a behavioral health issue that impacts both the at-risk and high-risk populations. This section focuses on the treatment or rehabilitation of Soldiers who have alcohol or drug addiction or dependency from a health perspective, while Chapter III covers illicit use of drugs and alcohol abuse associated with high-risk behavior from a disciplinary perspective.

(1) Drug and Alcohol Abuse as a National Issue

Drug and alcohol abuse continues to be a national issue. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 22.1 million Americans were classified with substance abuse or dependence in 2010. Among this population were 15 million dependent on or abusing alcohol, 4.2 million dependent on or abusing illicit drugs and 2.9 million dependent on or abusing both. This at-risk population includes all ages 12 years and older, a scale that increasingly touches young Americans

approaching the Army's recruiting population. "In 2010, the rate of substance dependence or abuse among adults aged 18 to 25 (19.8 percent) was higher than that among youths aged 12 to 17 (7.3 percent) and among adults aged 26 or older (7.0 percent)."⁷⁹

SAMHSA reported that prescription drug abuse among young adults was second only to marijuana. Pain relievers were the most commonly misused prescription drug "...with 2 million or more new... pain reliever [illicit]users each year since 2002, including over 500,000 who initiate [illicit] use without ever having used another illicit drug."⁸⁰ Pain reliever dependence increased from 936,000 to 1.4 million from CY2002-10 with about one-third (463,000) among the 18-25 year-old population. Illicit narcotic use translated into an increase from 145,000 to 306,000 emergency room interventions from CY2004-08; based on increased illicit narcotic use, this number can be expected to rise significantly in subsequent years.

The proliferation of prescription medications has dramatically increased opportunities for illicit use. Research indicates that the US has experienced a "nine-fold increase (5 million to 45 million) in prescriptions for stimulants from CY1991 to CY2010; opioid analgesics experienced a six-fold increase (30 million to 180 million) during this same time period."⁸¹ In addition, SAMHSA data indicates that 3 million Americans abused a prescription drug for the first time in the 12 months preceding its report, which means that there were 8,100 new illicit users every day. "About one-quarter initiated with psychotherapeutics (26.2 percent, including 17.3 percent with pain relievers, 4.6 percent with tranquilizers, 2.5 percent with stimulants, and 1.9 percent with sedatives)."⁸² Average age among new illicit users by drug category include: 16.3 years for inhalants, 18.4 years for marijuana, 19.4 years for Ecstasy, 21.0 years for pain relievers, 21.2 years for cocaine and stimulants, 21.3 years for heroin and 24.6 years for tranquilizers. Intuitively, first-time illicit drug users seem to follow a step-up type pattern that reflects both drug availability and cost.

SAMHSA 2010 survey data on alcohol consumption revealed that over half (51.8%) of the US population reported regularly consuming alcohol. Of these 131 million alcohol drinkers, approximately 33 million (23%) participated in binge drinking within the past month. Of the 33 million binge drinkers, a disturbing 93% were between the ages of 16 and 25 years old; again, the focused cohort for Army recruitment. Given the prevalence of alcohol associated with service-related—in particular combat-related—behavioral health issues, excessive alcohol use should be considered during pre-accession screening. This is particularly important given the fact that changes in alcohol consumption patterns (e.g. self-medicating, increased dependence, addiction) have been identified as a potential leading indicator of susceptibility to these occupational behavior health issues.⁸³

LEARNING POINTS

- ★ Consideration of excessive alcohol use among recruit candidates may reduce the prevalence of alcohol associated with service-related behavioral health issues.

(2) Impact of Drug and Alcohol Abuse on the Force

Soldier incidents of drug and alcohol abuse (i.e., drug offenses, drunk and disorderly offenses and DUIs) have generally trended upward from FY2006-09 (28,740 to 34,586 offenses) followed by a 10% decrease in FY2010 (31,617 offenses) and another 4% decrease in FY2011 (29,708). Drug and alcohol referrals also provide another good news story; referral rates increased from FY2004-11 with over 24,000 Soldiers referred to the Army Substance Abuse Program (ASAP) in FY2011 alone. This clearly indicates an increase in command (and to some extent Soldier) involvement in drug and alcohol

rehabilitation. Among those Soldiers referred, ~50% were subsequently enrolled into ASAP each year. Program enrollment was based on a clinical assessment for potential substance addiction or dependency, which explains the 50% gap between referrals and enrollments.

VIGNETTE—SURVEILLANCE OF DRUG AND ALCOHOL

A SPC tested positive for cocaine use in March 2007. He was not enrolled in ASAP and a DA Form 4833 was never completed. Despite 15 negative urinalyses from October 2008 to January 2011, he self-enrolled in ASAP that month for cocaine abuse and marijuana and alcohol dependence. The SPC was apprehended in July 2011 for assault consummated by a battery (domestic violence). A review of law enforcement databases revealed these offenses were not the beginning or the end of the SPC's high risk behavior; he was arrested for criminal trespass, marijuana possession and evading arrest in 2003 -- three years prior to his delayed entry report date of August 2006.

While driving on an interstate highway on 15 November 2011, the SPC collided with another vehicle, killing him and two others instantly and injuring two others. He had been driving the wrong way on the highway for two miles at the time of the accident. While drug and toxicology results are unknown at this time, packets of Spice were found in the SPC's vehicle.

Similar to national trends, Soldier demographics in relationship to binge drinking are at the forefront of issues confronting the Army. Research indicates that as many as 43% of active duty Soldiers reported binge drinking within the past month. Of this population, "...67.1% of binge episodes were reported by personnel aged 17-25 years with 25.1% representing underage youth (aged 17-20 years)."⁸⁴ This is consistent with one article that indicates "...on the basis of mass media reports, diagnoses of alcoholism and alcohol abuse increased 6.1 per 1000 Soldiers in 2003 to an estimated 11.4 as of March 31st 2009."⁸⁵

Excessive alcohol use is even more troubling because alcohol abuse is associated with a variety of physical and behavioral health issues related to combat service. For example, "[v]eterans who were problem drinkers were 2.7 times as likely to have PTSD as veterans who were not problem drinkers."⁸⁶ In another study, 25% of 275 Soldiers were identified with alcohol abuse 3-4 months after deployment and 12% exhibited alcohol-related behavioral problems.⁸⁷ The same study found that "Soldiers who had higher rates of exposure to the threat of death / injury were significantly more likely to screen positive for alcohol misuse," which was followed by a recommendation that Army healthcare closely follow Soldiers who screen for alcohol abuse during reintegration. Unfortunately, this may not be happening. Based on a study from Walter Reed Army Institute of Research, Soldiers reported alcohol problems on the Post-Deployment Health Assessment (PDHA) at a rate of almost 12%, but only 2% of those who reported alcohol problems were referred for evaluation or treatment (this 2% referral rate is significantly lower than referral rates for other behavioral health concerns).⁸⁸

The Reserve Component and civilian veterans also struggle with the effects of alcohol and drug abuse, dependency and addiction. According to the American Medical Association, "[c]ompared with Active Component Soldiers, Reserve Component Soldiers had a similar overall rate of alcohol misuse, but 44% higher odds of drinking and driving, along with 56% lower odds of entering treatment."⁸⁹ Their research found "...a significantly increased risk for new-onset heavy weekly drinking, binge drinking, and other alcohol-related problems among Reserve / Guard [Soldiers] deployed with reported combat exposures compared with non-deployed Reserve / Guard [Soldiers].” The research goes on to conclude possible explanations for the increase in new-onset drinking to include: (1) inadequate training and preparation for added stresses of combat exposure, (2) increases in Soldier and Family transition back to

civilian occupational settings, (3) lack of military unit cohesiveness, and (4) reduced access to health, family, physical fitness and ongoing prevention programs.⁹⁰

In a broader context, Iraq and Afghanistan Veterans of America reported in 2009 that 7,400 Iraq and Afghanistan veterans were treated by the VA for drug addiction, 27,000 new veterans had been diagnosed “with excessive or improper drug use” and 16,200 had been diagnosed with alcohol dependence. Their report concluded that “[t]hese numbers are only the tip of the iceberg; many veterans do not turn to the VA...instead relying on private programs or avoiding treatment altogether.”⁹¹ A recent update by the VA confirms the potential for a larger underreported population, indicating a 20% increase in alcohol abuse and a 19% increase in drug abuse from 2008-10.⁹²

LEARNING POINTS

- ★ Drug and alcohol referrals provide a good news story; referral rates have increased year over year indicating an increase in command involvement in Soldier rehabilitation.
- ★ Soldiers reported alcohol problems on the PDHA at a rate of almost 12%, but only 2% of Soldiers reporting alcohol problems were referred for evaluation or treatment.

(3) Drug and Alcohol Treatment and Administration

Each year only ~ 52% (~10,000 Soldiers) of those referred to treatment for either drug or alcohol were actually enrolled into an outpatient treatment program. Of those enrolled, an average of 933 Soldiers fail drug rehabilitation and 1,416 fail alcohol rehabilitation annually (based on data from FY2001-10), with 1,055 Soldiers failing drug rehabilitation and 1,569 failing alcohol rehabilitation in FY2010 alone.² On the flip side, an average of 1,119 Soldiers successfully complete drug rehabilitation and 4,985 successfully complete alcohol rehabilitation annually, with 1,116 Soldiers successfully completing drug rehabilitation and 6,603 successfully completing alcohol rehabilitation in FY2010. The discrepancy between program success and failure numbers vs. total enrolled numbers can be attributed to those Soldiers that for various reasons (e.g., ETS, deployments) did not complete the program. The average annual successful-completion rates from FY2001-10 were 47% and 66% for drug and alcohol rehabilitation, respectively.

The chart at figure II-7 illustrates recidivism (or relapse) rates for drugs and alcohol at the 1-year and 5-year post treatment periods for those Soldiers who successfully completed rehabilitation. Consistent with lower successful-completion rates, drug recidivism rates are higher on average than alcohol recidivism rates for both periods. As expected, 5-year trends for drug and alcohol recidivism demonstrate a

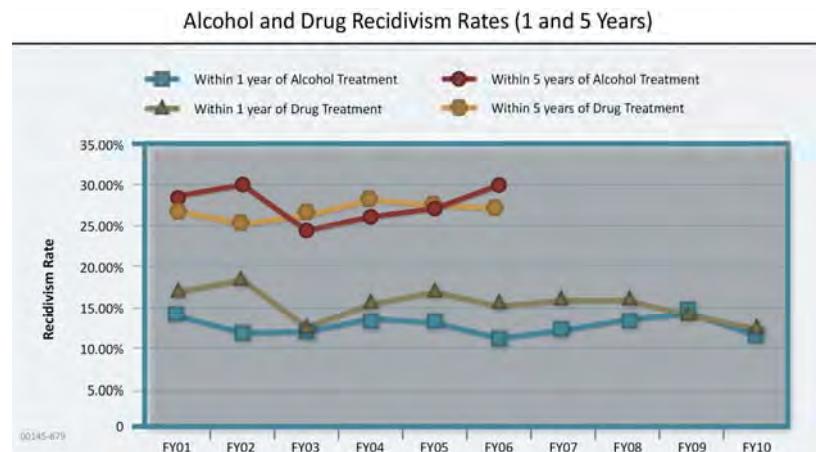


Figure II-7: Alcohol Recidivism Rates, FY01-10

² FY10 numbers are used rather than FY11 to preclude those still undergoing treatment in FY11.

significantly higher rate over their first year periods. Also, recidivism trends for both drug and alcohol treatment appear relatively stable over time, providing a consistent benchmark for measuring treatment success. This information can be helpful to leaders when considering Soldier treatment, discipline and administrative measures, as it can inform commanders regarding the potential for return on investment.

One cautionary note regarding the Army's recidivism rates: recidivism rates for Army drug and alcohol treatment are only a measure of a post-treatment adverse event, meaning that a Soldier had another alcohol or drug event following successful treatment. In other words, recidivism is simply a measure of whether a Soldier was caught again. This may explain why the Army's recidivism rates are lower than national trends, which rely on more subjective criteria. Like drug detection, for example, Army recidivism statistics are generally based on random and infrequent drug testing or an actual alcohol-related incident. However, alcohol could have a significant impact on performance and readiness long before it is manifested as an outcome of an adverse event. Finally, recidivism rates may be underreported because they do not account for separated Soldiers when calculating the 1 and 5 year recidivism rates (and who, had they not been separated, would have been counted as a recidivist).

Drug and alcohol separations are a critical consideration during the chain of command's evaluation of this at-risk population. Criteria for separations should consider behavioral health and disciplinary measures to optimize unit and Soldier readiness. These criteria should include collaboration among the health triad to determine the Soldier's potential for successful rehabilitation, likelihood for recidivism and the impact of service-related stressors on the Soldier's long-term health. Simply put, there are times when, after weighing the totality of the circumstance, a Soldier must be placed in the sanctuary of a less stressful occupation. After all, the Army exists to fight and win the Nation's wars.

VIGNETTE— SOLDIER CREDITS ASAP FOR SAVING HIS LIFE

A former NCO suffered from PTSD caused by combat stress, including loss of a Soldier and witnessing an Iraqi child die. He kept his diagnosis to himself due to a perceived stigma associated with PTSD. As he told his story, "I kept it to myself because the stigma is that [PTSD] is a burden on the command." Suffering under a post-deployment drug habit and stressed by demotion, a failed marriage and separation from his young daughter, he contemplated suicide. He did not attempt suicide and was eventually enrolled into ASAP. Following rehab he was free from his habit of crack cocaine for almost nine months, until his ex-wife informed him that he was not the man that she wanted in her life. He immediately relapsed, consumed drugs and was detected by a urinalysis (UA) sample taken the next day. Upon being confronted with the urinalysis test results he went home and placed a loaded gun to his head but a photo of his daughter changed his mind.

He is now enrolled back in ASAP and credits it with saving his life, "Being a drug addict, sometimes there comes a point when you really think there's no other way out." Although he is facing separation the former NCO has taken his message public with hope that he can save others. As he noted, "I think that one thing that other Soldiers need to do is stop blaming other people. I've taken full responsibility for everything I've done and the poor personal decisions I've made. I'm not going to let this beat me. I look at drug addiction as a battle." As he described his near fatal incident, "I felt sorry for myself for about 30 minutes when they took my rank, but I got back up. Like I said, when I looked at my daughter, that's what really counts to me."⁹³

LEARNING POINTS

- ★ The average annual successful-completion rates from FY2001-10 were 47% and 66% for drug and alcohol rehabilitation (respectively) which are well above national rates for similar treatment.

(4) Policy and Programs

The Army has made significant progress in implementing drug and alcohol policy over the last few years, but there is still more work required to close current gaps between policy intent and implementation. Commanders have improved policy implementation with respect to alcohol and drug abuse, referrals to treatment, and Soldier drug and alcohol-related separations as they close in on historic norms. Likewise, program managers have improved treatment enrollment rates and communication among the health triad regarding the effects of treatment on Soldier performance / readiness. Additionally the Army continues to examine the effects of new policy and programs to reduce risk associated with alcohol and drug abuse, such as Confidential Alcohol Treatment and Education Pilot (CATEP) and the Army's Drug Take Back program. It also continues to refine existing policies to increase alcohol and drug surveillance, detection and response including limiting prescription duration, evaluating polypharmacy impacts, testing all Soldiers, expanding drugs tested and prohibiting emerging synthetic drugs. In this subsection, policy and programs focus on the health of the Force, but other alcohol and drug policy as it pertains to discipline of the Force will be discussed in Chapter III.

Chapters 9 and 14 (as prescribed by AR 635-200, in concert with AR 600-85) provide the administrative separation mechanism for substance abuse-related behaviors. Army policy requires commanders to *initiate* administrative separation for a first time drug offense or second alcohol-related incident in a 12-month period. Additionally, policy requires commanders to *process* separation for a second time drug offense or a second incident of driving under the influence of alcohol. The Army continues to improve its separation rates as depicted in figure II-8.

Chapter 9 separations have more than doubled, up 117% from their low of 194 in FY2006 to 421 in FY2011, recapturing pre-war separation rates. Chapter 14 separations for drug abuse have steadily increased from FY2001-11 by 261% from a low of 862 in FY2001 to 3,116 in

FY2011. This change in

separation rates reflects improvements in leader implementation year over year, particularly following the surge in Iraq. Additionally, data reveal that commanders are separating Soldiers for their first drug offense at an increasing rate, which is likely appropriate based on the totality of the circumstances and well within the intent of Army policy.

During the course of drug rehabilitation, AR 600-85 specifies that “if the unit commander determines that conduct, duty performance, and progress are unsatisfactory, and that further

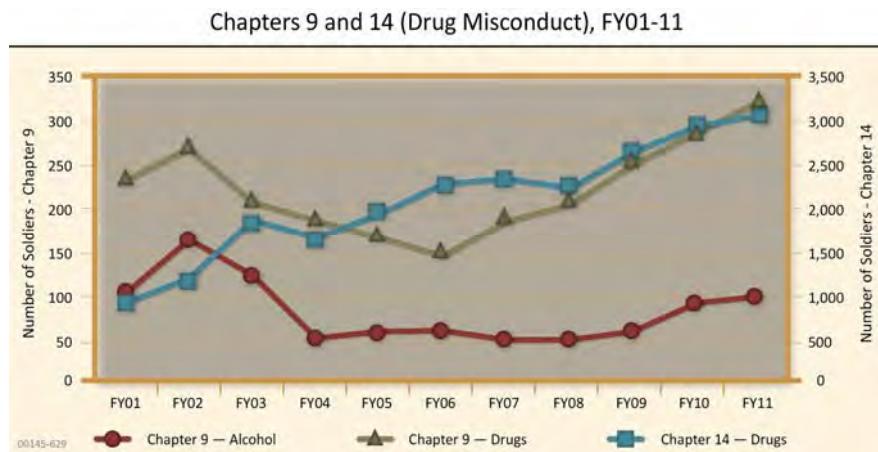


Figure II-8: Chapters 9 and 14, FY01-11

separation rates reflects improvements in leader implementation year over year, particularly following the surge in Iraq. Additionally, data reveal that commanders are separating Soldiers for their first drug offense at an increasing rate, which is likely appropriate based on the totality of the circumstances and well within the intent of Army policy.

rehabilitation efforts cannot be justified, they will initiate a discharge [via Chapter 9, AR 635-200] from military service.” However, a review of Chapter 9 separation data revealed that this chapter is significantly underutilized to separate drug and alcohol rehabilitation failures. While an average of 933 and 1,416 Soldiers failed drug and alcohol rehabilitation each year, Chapter 9 was only used an average of 287 times. Although Chapter 14 can also be used to separate Soldiers, it is specifically designed as an administrative measure to address misconduct. For administrative separations related to health, Chapter 9 is better suited for health issues which affect the ability to serve and may provide additional benefits upon transition to VA healthcare.

Another emerging policy effort involves confidential treatment programs. The CATEP initiative, for example, opens the door to the possibility that Soldiers who self-refer for alcohol problems can receive the same level of confidential treatment as Soldiers being treated for other medical / behavioral health conditions. As the Army expands confidential treatment access and delivery, it has also expanded the policy debate. Feedback from commanders indicates a growing concern that they are left out of the loop on critical information pertaining to Soldier performance and readiness. A recent 2011 CATEP survey provided the following critique from leaders spanning first-line supervisors through commanders: “leaders support Soldiers getting treatment, however, they oppose not being informed of Soldiers’ participation in treatment; many feel that confidentiality detracts from their ability to effectively help and lead Soldiers and diminishes overall unit readiness.”⁹⁴ This issue stands out in stark contrast to other policy initiatives—Health Insurance Portability and Accountability Act (HIPAA) exemptions for one—that have sought to increase communication and collaboration among the health triad.

The need for such collaboration, however, is countered by other leaders who feel that confidentiality is essential to reducing stigma associated with behavioral health. The same survey, for example, posed a contrary view, stating “commanders will initially oppose CATEP, however, as pointed out during stigma study focus groups, commanders have said ‘I would rather the Soldier receive treatment, even if I am not notified, than for the Soldier to receive no treatment at all.’”⁹⁵ Furthermore, many feel that because CATEP is designed to help those who self-refer (e.g., had no incident arising to command level and were self-motivated), the program’s treatment benefits likely outweigh any detriments caused by lack of command oversight. CATEP proponents assert that even if participants do not complete the program, they will benefit from receiving an evaluation, being informed of any addiction or dependency issues, and being offered treatment.

LEARNING POINTS

- ➊ Army policy requires commanders to *initiate* administrative separation for a first time drug offense or second alcohol-related incident in a 12-month period; and *process* the separation for second time drug offense.
- ➋ For administrative separations related to health, Chapter 9 is better suited for service-related health issues and subsequent transition to VA healthcare.
- ➌ In the ongoing debate between confidentiality and the need for command awareness, CATEP provides information, diagnosis and treatment for Soldiers who have not had an alcohol related incident associated with their self referral.

e. Stress

The term “stress” was coined by Hans Selye in 1936, who defined it as the “non-specific response of the body to any demand for change.”⁹⁶ Dr. Robert Sapolsky, a leading neuroscientist, has since conducted extensive studies on the physical and emotional impacts of stress on the human body. Stress, according to Sapolsky, enables an effective ‘fight or flight’ response to danger, “making us run from predators and enabling us to take down prey.”⁹⁷ In response to stress, the body releases hormones, perhaps best understood as the ‘adrenaline rush’ a person feels when he or she is caught by surprise or frightened. Stress also drives productivity, motivating an individual to perform and accomplish at a higher rate. In other words, there is positive stress.

However, there is a point where stress, whether positive or negative, can become counterproductive or even dangerous to an individual’s health and well-being. In particular, significant problems may occur when individuals experience this same life-saving (“fight or flight”) physical reaction recurrently or for sustained periods while attempting to cope with common non-life-threatening circumstances or events such as unemployment, work-related pressures, financial demands and day-to-day annoyances (e.g., traffic jams, long lines at retail stores). Affected individuals are “...constantly marinating in corrosive hormones triggered by the stress response.”⁹⁸ This, in turn, contributes to the development of potentially serious physical and behavioral health conditions such as heart attacks, stroke, lower back pain and depressive disorders.

The long-term health impact of chronic stress is particularly concerning as it pertains to Soldiers and other members of the military. The persistent high OPTEMPO on today’s battlefields, coupled with the non-contiguous nature of warfare, allows individuals very few opportunities to rest or relax, physically or mentally. For periods often lasting several months or even years, they are frequently in situations that trigger a “stress reaction” (e.g., riding in convoys with the ever-present threat of IED attacks, witnessing a buddy killed or severely wounded). The cumulative effect is likely to negatively impact an individual’s long-term health. In fact, we are already seeing such symptoms among our Soldier population. According to a recent study of redeployed combat veterans, sleep disturbances and problems with sleep-disordered breathing are common; likewise, those with a diagnosis potentially related to combat stressors (e.g., PTS, major depression, anxiety disorder, etc) had a higher incidence of sleep disturbances.⁹⁹

Recognizing this, leaders and others must understand that the threshold between “good stress” and “distress” differs for every individual.¹⁰¹ As illustrated in figure II-9, there is an optimum range between good stress and distress where performance is enhanced, but increased stress in either direction will decrease performance. Acute or prolonged distress can lead to fatigue, exhaustion and eventually to physical or behavioral health issues. Some may be able to withstand significant amounts of stress, including those stressors unique to combat environments, while others may be overwhelmed by seemingly innocuous events or pressures. Researchers are still trying to determine what makes some individuals more vulnerable to the effects of

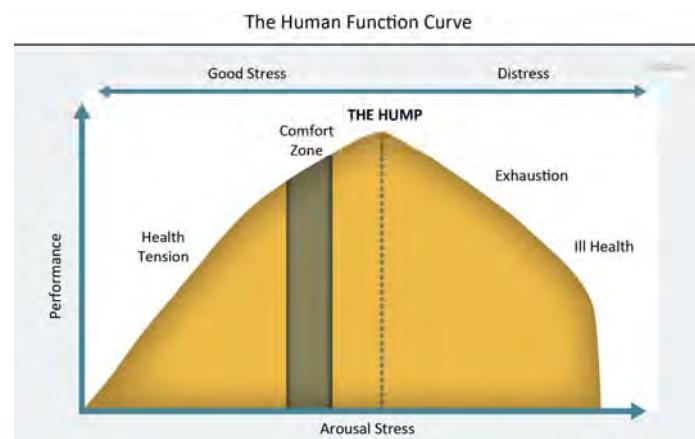


Figure II-9: The Human Function Curve¹⁰⁰

stress than others. Genetics, as well as pre-existing or previous conditions (e.g., prenatal stress, traumatic events experienced as a child) seem likely factors. There are promising efforts underway to develop a “stress vaccine” that would, according to Dr. Sapolsky, “neutralize the rogue hormones before they can cause damage.”¹⁰² However, until such a remedy is proven effective and made readily available, individuals must learn to mitigate or manage stress as much as possible, while also further improving their coping skills. In recognition of the impact of stress, the Army published FM 6-22.5, *Combat Operational Stress Control (COSC) Manual for Leaders and Soldiers*, March 2009, to assist leaders in preventing, reducing, identifying and managing combat and operational stress reactions at tactical levels. The importance of this training is highlighted in Chapter 1 of the manual:

Historically within US military operations, COSRs [combat and operational stress reactions] have accounted for over half of battlefield casualties, depending on the difficulty of the conditions. As a result of COSC being recognized as one of the ten AMEDD [Army Medical Department] functions that is required for support of full spectrum operations, losses due to COSR have significantly decreased. In today’s operational environment, leaders can expect to retain and have returned to duty over 95% of the Soldiers who have COSR. Combat and operational stress control is a tactical consideration that must not be overlooked or minimized.¹⁰³

LEARNING POINTS

- In recognition of the impact of stress, the Army published FM 6-22.5, *Combat Operational Stress Control Manual for Leaders and Soldiers*, March 2009, to assist leaders in preventing, reducing, identifying and managing combat and operational stress reactions at tactical levels.

(1) Army Transitions and Stressors

The Composite Life Cycle

Model, first introduced in the *Red Book*, was designed to provide an aggregate view of the unique “transitions” that occur in each of the three separate military life cycle strands of Unit, Soldier and Family (figure II-10). The model provides two ways to view the impact of the innumerable transitions and subsequent stressors impacting Soldiers and Families: (1) horizontally across time within a particular strand, and (2) vertically across all three life cycle strands at a particular point in time. The first view illustrates the potential acute and recurring stressors associated within each strand, while the

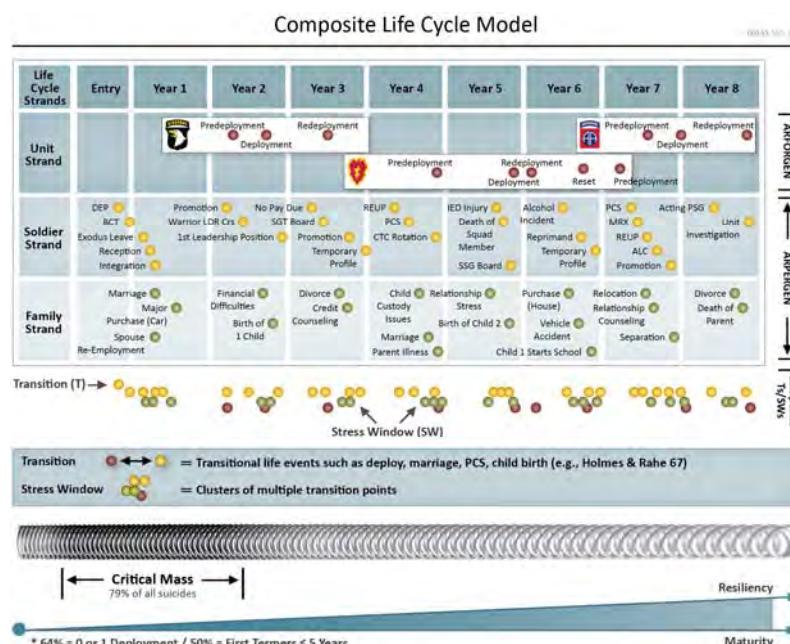


Figure II-10: Composite Life Cycle Model¹⁰⁴

second illustrates the potential for cumulative stressors from all three strands. This model continues to be a useful tool for commanders and other leaders, enabling them to better understand, appreciate and

proactively counter acute, recurring and cumulative stress on Soldiers and Families. As indicated by its name, Composite Life Cycle Model, leaders must consider each life cycle strand in relationship with the other life cycle strands to holistically understand the impact of multiple transitions and stressors on Soldiers and Families.

Although the model depicts transitions / stressors that realistically occur in each year of service for the first eight years, it is equally applicable to the subsequent years of a full career. The message is clear; OPTEMPO (as measured by transitions) does not slow down over the course of a career. The unit strand is the most visible among the three strands and measures the life cycle of the unit through deployment, redeployment and reset. Its real impact, however, is on the individual Soldiers assigned to the unit who experience the stress associated with deployment cycles. The bar chart at figure II-11 illustrates current deployment OPTEMPO by measuring months of dwell for Soldiers with deployment experience but who are currently not deployed. It clearly highlights the fact that only 31% of the Soldiers currently meet the Army goal of a minimum of two years at home station for every year deployed. As the Army works to achieve this interim goal, it is also revising long-term policy to set deployment lengths from one year to nine months and Boots on the Ground (BOG):Dwell from 1:2 to 1:3.

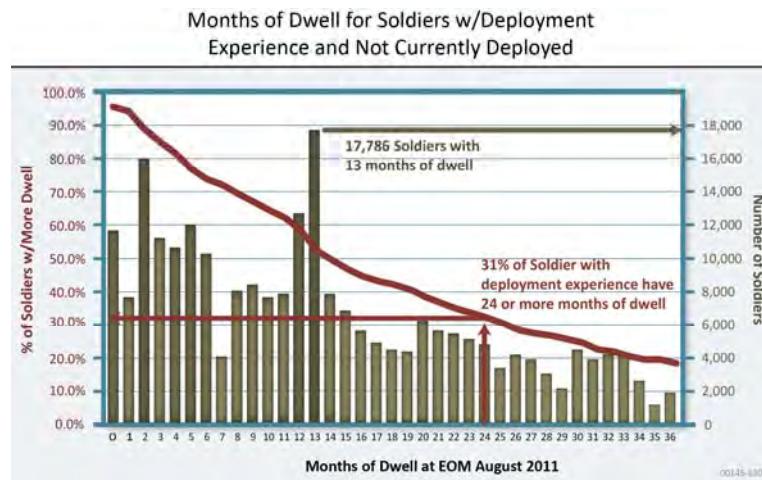


Figure II-11: Months of Dwell Time¹⁰⁵

Next, the Soldier strand highlights routine transitions / stressors associated with individual military service ranging from administrative, disciplinary and occupational activities to service-related health issues. These transitions, which can amplify individual stress, routinely occur in conjunction with the unit deployment cycle. This means that a Soldier can experience stress from transitions in both the unit strand (e.g. deployment stress) and the Soldier strand (e.g. career stress). For example, Soldiers may receive administrative or disciplinary action even while enduring the stress of a deployment.

VIGNETTE—SOLDIER STRESSORS TRANSMIT TO FAMILY STRESSORS

In November 2011, the wife of a 20-year-old PVT woke up to feed her 10-month-old daughter and found her cold to the touch. EMS technicians arrived at the off-post residence but were unable to revive her. Local police assessed the house as messy and unsanitary. The residence was without heat or electricity. According to the PVT (who lived in the barracks due to disciplinary issues), utilities were shut off due to unpaid bills. The wife stated she started a charcoal grill in the interior hallway to heat the residence. Autopsy results revealed the child died from carbon monoxide poisoning from the grill. The wife remains under investigation for negligent homicide and child abuse. The PVT is pending discharge for a pattern of misconduct unrelated to this death.

Finally, the Family strand highlights normal recurring transitions and stressors associated with military family life. Together these strands highlight the potential harmony and, perhaps more often, the discord experienced by leaders and Soldiers as they attempt to manage unit, career and Family

transitions / stressors. It goes without saying that stress of deployments, promotions, job transitions, child birth or needs of an aging parent may occur in close proximity or even coincide at a single point in time. In fact, we are seeing the adverse effects of stress impacting three specific sub-populations: spouses, children and caregivers. These sub-populations are under increased pressure due to a variety of factors, such as deployments and subsequent lengthy separations, anxiety or concern for the safety and well-being of loved ones serving in combat environments, and the increased demands of single parenthood.

Adult relationships among Army Families are strained from the impact of significant transitions in the early service years; these transitions often occur before growth in resiliency, coping skills and help-seeking behavior. A significant portion of the Force is made up of junior enlisted Servicemembers, most ranging in age from 19-22 years old. Many are married with young children, on tight budgets, and with spouses who are often far removed from extended Family, shouldering a tremendous amount of responsibility at a very young age. A rise in family stress was consistent with findings from a recent Defense Manpower Data Center (DMDC) survey of Army spouses. The survey found an increasing number of spouses who reported experiencing stress, which was up from 46% in 2006 to 56% in 2010. Among this population, 44% reported that they were concerned about their finances, with only 34% reporting that they had more than \$500 in their savings. Additionally, of the 54% of Army spouses who were working or looking for work (i.e., in the labor pool), 29% were unemployed. Finally, 19% of those surveyed reported that they were undergoing counseling with the majority seeking therapy for stress, family issues and marital issues.¹⁰⁶ Additionally, as discussed under other sub-sections in this chapter, combat and stress-related behavioral health issues are impacting Army Families. For example, among Soldiers with deployment experience who suffered from depression "... greater than 50% reported being severely impaired at home, work, in relationships and social activities."¹⁰⁷

*"I met too many young parents in the infantry who were justifiably overwhelmed with the competing demands of going to war and raising kids, two pursuits that do not fit naturally together. Fights over finances, video game addiction, and infidelity were common, and too often this escalated into substance abuse, domestic violence, child maltreatment, and / or divorce."*¹⁰⁸

*– Dr. Michael Miovic, MD
Psychiatrist / US Army Contractor*

Children of military Families also experience high levels of stress. They routinely endure unique challenges, including repeated moves, parental separation due to deployments and, in some instances, the trauma of a parent's death or return from deployment with a combat injury or illness. Stress levels may be especially high during periods of deployment for a number of reasons including concern for the deployed parent's safety and high stress levels in the parent who remains at home. In fact, according to a longitudinal study conducted in 2009 by the Journal of Developmental & Behavioral Pediatrics (JDBP), "[t]he mental state of the remaining parent was deemed the 'single most influential factor in determining how well a child adjusts,' even more so than multiple deployments or the threat of injury or death of the deployed parent."¹⁰⁹ Whatever the cause, the added stress on children and teenagers often manifests in increased incidence of emotional and behavioral problems. For example, one study found that children of a parent deployed to Iraq or Afghanistan for longer periods are more likely to be diagnosed with a behavioral health issue when compared with children of parents who did not deploy. The same study concluded "[t]he strongest associations were for acute stress reaction and adjustment disorders, depressive disorders and behavioral disorders, among the total of 6,579 mental health diagnoses observed in children of deployed parents."¹¹⁰

The short- and long-term impact of these behaviors and associated periods of elevated stress on children's psychological development can be quite significant. According to the JDBP study, children of Servicemembers are 2.5 times more likely to develop psychological problems than American children in general.¹¹¹ This finding was consistent with research conducted by the American Academy of Pediatrics, which concluded that "[c]hildren of parents who are deployed during wartime experience ambiguous loss and stress, often beyond normative levels, that may become toxic if not detected and addressed in a timely manner."¹¹² Research also indicates some groups are more at risk, to include young children, children with pre-existing health and mental health problems, children in single-parent families with the parent deployed, and children in dual-military parent Families with one or both parents deployed.¹¹³ Consequently, it is important that caregivers, including parents, other relatives, medical providers and teachers, recognize symptoms of stress in children and teenagers (e.g., anger, acting withdrawn, trouble sleeping, low self-esteem), intervene as early as possible, and help them to develop positive coping skills and strengthen their resiliency.¹¹⁴

Finally, stress on military family caregivers may result in caregiver fatigue among this sub-population. Grandparents or other Family members are often required to serve as full-time guardians for children whose sole parent or parents are deployed. This can be particularly stressful, especially for elder caregivers who, having already raised a family and retired, are accustomed to a slower pace of life with significantly fewer responsibilities. Also, due to advances in combat medicine and protective equipment, an increasing number of Soldiers are surviving once fatal injuries, now returning home with debilitating physical injuries and behavioral health issues (e.g., amputations, PTSD) requiring long-term or around-the-clock care. Spouses, partners and, in some cases, parents are compelled to leave their jobs and dip into their savings or retirement funds to care for them. This can add significantly to their levels of stress as they worry about finances, competing responsibilities (e.g., parental obligations to young children), health concerns and the way ahead.¹¹⁵

VIGNETTE— LOOKING AFTER A VETERAN

A Servicemember returned from a second deployment to Iraq in 2008 with TBI and PTSD. His wife was forced to quit her teaching job to for an extended period to care for him. As a result their life savings were depleted. She had to adjust her role to care for her husband who is dealing with a variety of behavioral health issues including short-term memory loss, impulsive behavior and anger. According to his wife, "The biggest loss is the loss of the man I married. His body's here, but his mind is not here anymore. I see glimpses of him but he's not who he was." This couple is part of a larger population of families with one spouse suffering from physical or behavioral health issues, which requires the other to shift to a care provider role. This often means that other significant responsibilities such as employment and parenting must take a back seat, creating additional stress for the entire family. This was certainly true for this wife who was subsequently prescribed antidepressants and anti-anxiety medications.¹¹⁶

As discussed earlier, transitions which can lead to acute, recurring or cumulative stress can ultimately affect the Soldier's physical / mental health, family dynamics, mission performance or individual and team readiness. The accumulation of transition points (associated with accompanying stressors) are illustrated by the clusters of red, amber and green dots at the bottom of the Composite Life Cycle Model shown in figure II-12. Although notional, they represent an average sequence of expected service-related transitions that impact the unit, Soldier and Family. These transitions may occur as a single event or in clusters, signifying multiple transitions / stressors occurring in close proximity or concurrently (e.g., deployment, birth of a child or administrative action). The larger clusters are labeled stress windows which may represent critical stress periods that can place individuals

at elevated levels of risk. As illustrated in the model, these stress windows appear abruptly and continue unabated throughout a Soldier's career. They represent transitions and stressors unique to the military that—from initial entry until separation—will likely outpace those associated with non-military occupations. In the words of the VCSA, "We have Soldiers today who are experiencing a lifetime of stress during their first six years of service."¹¹⁷

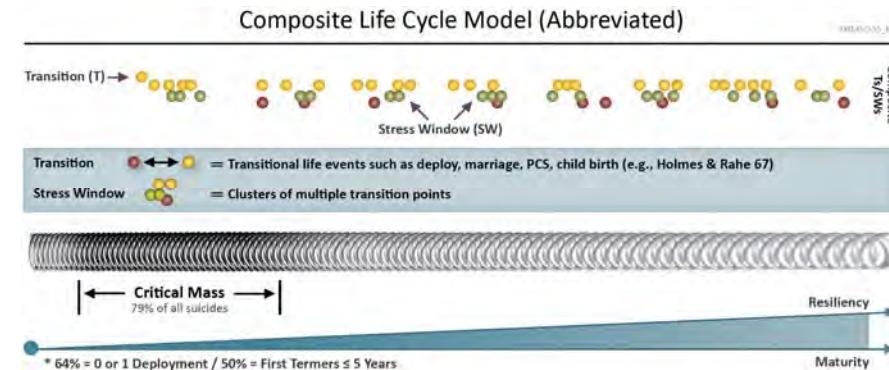


Figure II-12: Composite Life Cycle Model (Abbreviated)

The "coil" in the figure represents the effect of stress on Soldiers with increasing stress in the early years that subsides over time as Soldiers grow in resiliency and maturity. In other words, the coil becomes more compressed as stress increases among new Soldiers and Families dealing with new and significant transitions / stressors (departing home, basic training, first few units and deployments, marriage, etc.). Conversely, the coil relaxes as stress is reduced or as the Soldier develops resiliency or adjusts to military life. The most vulnerable period, labeled critical mass, represents a time when Soldiers are at the greatest risk for self harm or suicide. This period has been adjusted to reflect the latest data on suicide with respect to deployments and in each of the first five years (first-term enlistment). As illustrated, non-deployers and one-time deployers have decreased from 75% of all Active Component suicides in FY2009 to 64% in FY2011. Suicides among first termers, however, have remained fairly consistent at approximately 50% of all suicides. Additionally, stress and triggering events for suicide among senior military members, at the far right of the coil, are often associated with investigations or legal and administrative actions that threaten professional status or career retention. In fact, approximately 50% of suicides among 22 Active Component senior leaders ($\geq E7$ and $\geq O3$) in FY2011 were related to these issues.

VIGNETTE— LEADERS UNDER INVESTIGATIVE / LEGAL STRESS

A 41-year-old SFC, deployed to Afghanistan, was interviewed by CID on 22 April 2011 for possession of child pornography and admitted to viewing child pornography. After the interview, the SFC's commander was briefed on the status of the investigation. The SFC was released to his commander. Around 0815, 24 April 2011, the unit commander went to check on the SFC and found his room door locked with no response. Upon gaining entry, the SFC was found unresponsive with a leather belt around his neck. Emergency Medical Services (EMS) responded and found him deceased. A search of the room found a note addressed to his wife stating, "I made some serious mistakes and cannot deal with what I have done."

The impact of transitions may be reduced by active leader engagement during the early years. Although the effect of transitions and stress may be easily illustrated by this model, surveillance and detection of the effects of stress and appropriate responses require effective collaboration among the health triad. Also, accelerating resiliency and maturity among Soldiers in the early years will reduce stress or at least help Soldiers mitigate its effects. The Army's Comprehensive Soldier Fitness program is helping Soldiers to become more resilient through development of coping mechanisms. Finally, leaders

must continue to reduce stigma associated with behavioral healthcare by ensuring that Soldiers clearly understand that sustaining their mental health is as important as sustaining their physical health.

LEARNING POINTS

- ★ The Composite Life Cycle Model provides a tool to increase dialogue among leaders and Soldiers to better understand the impact of transitions and stressors on Soldiers and Families.
- ★ There is a growing impact of war-related stress on children and teenagers (e.g., anger, acting withdrawn, trouble sleeping, low self-esteem) which is best countered by early intervention.
- ★ The impact of transitions on Soldiers may be reduced by active leader engagement during the early years.
- ★ Command emphasis that balances the importance of mental health with physical health will reduce stigma associated with behavioral healthcare.

(2) Policy and Programs

Senior leader involvement is undeniably the hallmark of effective policy and program implementation. The Army's Suicide Senior Review Group (SSRG), which is a monthly review among Army senior leaders, commanders and health / risk program managers, is an excellent example of this level of involvement. It is conducted for every suicide that occurs in the Army, but its primary focus is to review the transitions and stressors associated with the event to glean lessons learned to improve leader surveillance, detection and response to military stress. The SSRG critiques policy and programs associated with Soldier transitions and stress, behavioral health issues, high-risk behavior, stigma and leadership implementation to inform necessary adjustments or new policy / program formulation. This forum has also elevated the Army's comprehensive awareness of the effects of stress and renewed efforts to improve policy and program integration.

Since publication of the *Red Book*, the Army has made significant progress in policy and programmatic efforts to reduce stress through, for example, publication of new policies, manuals and campaign plans; increased funding for marriage enrichment programs (e.g., Strong Bonds); the hiring of additional Military Family Life Consultants (MFLCs), behavioral health specialists, and chaplains; increased web-based tele-health counseling services; and other initiatives underway as part of the Military Child Education Coalition. It also has integrated stress surveillance, detection and response through a new Comprehensive Behavioral System of Care with six touch points spanning from home station to deployed environments (as described under the *Behavioral Health Diagnoses and Treatment* (Chapter II, Section 1.a.).

The Army also has expanded Soldier connectivity through enhanced unit integration and reintegration programs—arguably the most critically effective policy in reducing stress. Leader and Soldier connectivity has been enhanced through an engaged health triad that has invoked appropriate military exemptions to HIPAA; improved implementation of Community Health Promotion Councils (CHPCs), Fatality Review Boards and other installation fusion forums; inclusion of stress-related planning and training in pre- and post-deployment cycles; increased family interaction through community and unit readiness forums; and increased reporting via the Department of Defense Suicide Event Report (DoDSER) and Commanders Suicide Event Report. Again, the latter reports are focused on identifying pre-event stress and triggers as a part of enhancing the Army's prevention efforts.

However, there is still much to be done. Given the scope and severity of the challenges we are

facing, Army leaders recognize the need to expand their efforts and continue to find new and innovative ways to help Soldiers and Family members to strengthen their resilience, better cope with stress and actively seek professional care. New and emerging transitions such as the pending Force reduction—amidst constrained resources and recessive economic conditions—or health transitions to the VA system will further necessitate engaged leadership at every level. Perhaps research has delivered the bottom line in that “[p]rotection from stress-related disease is most powerfully grounded in social connectedness.”¹¹⁸ Understanding this, we must ensure we are fostering a culture of connectedness based on a shared sense of community and a commitment to look out for one another.

LEARNING POINTS

- ❖ The Army has expanded Soldier connectivity through enhanced unit integration and reintegration programs—arguably the most critically effective policy in reducing stress.
- ❖ Command participation in the CHPC and other community fusion forums (e.g. Family Advocacy Program (FAP), ASAP, Sexual Harassment / Assault Response and Prevention (SHARP), Risk Reduction Program) will increase community and unit awareness and integration.

3. Challenges Facing Army Leaders and Healthcare Providers

a. Comorbidity (Polytrauma Triad / Symptoms)

Comorbidity, which is the co-occurrence of multiple physical or behavioral health issues simultaneously, is unquestionably the most complex health issue confronting a post-war Force. Although its definition is most often associated with formal diagnoses and medical symptoms, it must be understood by leaders in the health triad within the context of undiagnosed health-related issues among today's Soldiers and veterans. In essence, undiagnosed health issues compose a significant part of the complexity associated with comorbidity. As demonstrated throughout this chapter, it is almost impossible to discuss any combat-related physical or behavioral health issue without also discussing co-occurring or other closely associated health issues. For example, research behind each subsection above (e.g., PTSD, mTBI, or depression) repeatedly found the existence of other physical or behavioral health issues associated with that particular section. In fact, there are numerous examples in which research points to one health issue as a precursor or indicator of other health issues.

Prevalence of Chronic Pain, PTSD and TBI in a Sample of 340 OEF/OIF Veterans with Polytrauma

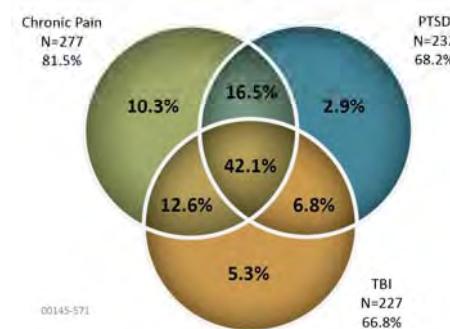


Figure II-13: Prevalence of Chronic Pain, PTSD and TBI¹¹⁹

The diagram at figure II-13 provides an example of comorbidity based on overlapping chronic pain, PTSD and TBI among veterans. Researchers conducted a blind records review of 340 veterans who were evaluated at a VA polytrauma center to determine legitimate diagnoses for these three health issues. They concluded that 42% were legitimately suffering from all three health issues, 78% had at least two and 96% had at least one of these health issues.¹²⁰ This finding is significant when generalized across a larger segment of the Army population that may be suffering from comorbidity. It underscores the importance of accurately diagnosing each health issue contributing to comorbidity. For example, current gains in screening and diagnosing mTBI will improve treatment of that particular aspect of

comorbidity. As research improves the diagnosis of other co-occurring health issues, similar advances in treating each medical issue will advance the treatment of comorbidity as a whole.

Numerous co-occurring physical and behavioral health issues can share common manifestations and symptoms, which further complicate diagnosis and treatment of any one health issue, let alone the other co-occurring health issues. The diagram in figure II-14 depicts a potential overlapping of multiple health issues (i.e., PTSD, TBI, chronic pain, depression, and substance abuse) that can impact Soldiers. Each Soldier can be adversely affected by one or more physical and behavioral health issues at the same time but each in very different ways. Soldiers with the same health issue or issues may experience different symptoms, symptom intensity and duration, or behavioral outcomes associated with these health issues.

Consequently, the symptoms (e.g., sleep disruption) and symptom manifestations (e.g., fatigue) experienced by a Soldier or the Soldier's resulting behaviors (e.g., irritability) do not necessarily indicate which health issue a Soldier may be suffering from. Many health issues have similar symptoms. The table at figure II-15 better illustrates this point. The symptoms of Postconcussive Syndrome (PCS) listed in the first column are all shared by mTBI, PTSD and chronic pain as indicated by the check marks in the last three columns.

PCS Symptoms*	Mild TBI	PTSD	Chronic Pain
Memory Impairment ^{1,2}	✓	✓	✓
Concentration Problems ^{1,2}	✓	✓	✓
Irritability ^{1,2}	✓	✓	✓
Insomnia/Sleep Problems ^{1,2}	✓	✓	✓
Fatigue ^{1,2}	✓	✓	✓
Headache ^{1,2}	✓	✓	✓
Dizziness ^{1,2}	✓	✓	✓
Intolerance of Stress, Emotion, or Alcohol ¹	✓	✓	✓
Affective Disturbance ²	✓	✓	✓
Personality Change ²	✓	✓	✓
Apathy ²	✓	✓	✓

* Postconcussive Syndrome (ICD-10) or Postconcussional Disorder (DSM-IV) diagnoses requires 3 or more of these symptoms as well as a head injury with the loss of consciousness (ICD-10) or head trauma with amnesia, LOC, or seizures; neuropsychological impairment; and social problems (DSM-IV).

¹ICD-10 criteria ²DSM-IV criteria

Figure II-15: mTBI, PTSD and Chronic Pain Symptoms¹²²



Figure II-14: Overlapping of Multiple Health Issues¹²¹

Comorbidity can also mask the deeper root causes associated with symptoms or other behavioral manifestations. Research found that “[p]revalence rates for PTSD or depression with serious functional impairment ranged between 8.5% and 14.0%, with some impairment between 23.2% and 31.1%. Alcohol misuse or aggressive behavior comorbidity was present in approximately half of the cases [reviewed].” Moreover, the same research found that while diagnosis rates remained stable among Active Component Soldiers over time, diagnosis rates increased from 3-12 months post-deployment for National Guard Soldiers.¹²³ This research may infer that Soldiers suffering from PTSD may likely be involved in alcohol / drug abuse and / or involved in spousal abuse, self-medicating in the first instance and acting out their heightened aggression in the second.

Adverse behavior may affect the perceptions of the chain of command, Family members or others in the Soldier's social circle. High-risk behavior (such as substance abuse or aggression) may be viewed as potential misconduct in isolation, rather than behavior associated with physical or behavioral health issues. This may also be true with respect to the impact of health issues on mission and personal performance. This is consistent with other research that concluded that "[m]ajor depressive disorder, [PTSD], and generalized anxiety or panic disorder were significantly associated with impairments in mental-interpersonal demands, time management, and output. Alcohol dependence and illicit drug use were associated with impairments in output and physical demands. On average, these productivity losses were four times those found in a previous study of non-veteran employees with no psychiatric disorders." The same research concluded that performance associated with behavioral health issues could significantly impact Soldier transitions to civilian life and future employment.¹²⁴

VIGNETTE— MRAP ROLLOVER SCENARIO

A Mine Resistant Ambush Protected (MRAP) vehicle is struck by an IED causing a vehicle rollover. The gunner is crushed in the rollover and dies within minutes. The driver experiences a concussive event, losing consciousness from the IED blast and blast overpressure; he also herniates three discs in his upper back.

The team leader receives a concussion with no tell-tale signs of the incident—he never lost consciousness and is capable of providing a backbrief of the incident to his chain of command following his evacuation from the scene. He experiences mTBI (undiagnosed) and delayed onset of PTSD three months after returning home. However, because of the late onset of PTS symptoms and undiagnosed mTBI, the team leader remains at increased risk for long-term health issues.

The driver suffers moderate TBI from the concussion, PTSD from the loss of his buddy and suffers chronic pain from the back injury. Based on loss of consciousness and immediate onset of PTS symptoms he is diagnosed and treated.

Both the driver and team leader at some point will complain of similar symptoms. What health condition are they describing? Based on the same set of symptoms, diagnosis and treatment will be complicated.¹²⁵

Contemporary leaders must have a deeper appreciation for the complexity of comorbidity and its impact on Soldier populations. This requires leaders to effectively communicate and collaborate as part of the health triad partnership. While unit leaders are not expected to diagnose health issues, understanding their impact on Soldiers and Families will improve surveillance, detection and response across this at-risk population. A fuller appreciation will more appropriately adjust supervisory expectations regarding the complex physical and behavioral health challenges confronting Soldiers, especially with respect to extended treatment requirements, therapy options and potential health setbacks. It will also help leaders to balance their response to risky behavioral outcomes, placing potential health before disciplinary considerations.

LEARNING POINTS

- ★ Soldiers with the same health condition or conditions may experience different symptoms, symptom intensity and duration, and behavioral outcomes associated with these health issues.
- ★ High-risk behavior (such as substance abuse or aggression) viewed in isolation may be misperceived as potential misconduct rather than behavior associated with physical or behavioral health issues.

★ While unit leaders are not expected to diagnose health issues, understanding their impact on Soldiers and Families will improve surveillance, detection and response across this at-risk population.

b. Prescription Medications

After a decade of war, an increasing number of Servicemembers are returning home from combat with conditions requiring prescription medication treatment, including pain from a variety of wounds, injuries and illnesses, and behavioral health conditions. Improvements in the delivery of battlefield medicine and Soldier protective equipment have led to fewer combat deaths; however, there is a higher survival rate of casualties requiring more long-term pain management. Pain alone is a leading cause of short- and long-term disability among military personnel, as indicated in the 2011 US Army Posture Statement. Roughly 47% of Soldiers returning from Iraq and Afghanistan report pain-related problems and symptoms.¹²⁶ In addition, the prevalence of behavioral health conditions, known for their increased complexity with regard to accurate diagnosis and treatment, has added appreciably to the demand on our military healthcare providers to provide treatment, often in the form of medication.

In order to provide patients relief, providers have frequently prescribed pharmaceuticals, including pain narcotics and psychotropic drugs. “Psychiatric drugs have been used more widely across the military than any previous war.”¹²⁷ According to a report on the Department of Defense 2012 budget submission, “14 percent of US Soldiers had been prescribed an opioid painkiller, with oxycodone accounting for 95 percent of those prescriptions.” According to this report, “25-35 percent of wounded Soldiers are addicted to prescription or illegal drugs while they await medical discharge.”¹²⁸ It is important to note, however, that research counters the assertion that the Army is overmedicating the Force. One study found that pain medication use was much lower in a random sample of Army male Soldiers than a demographically adjusted sample of civilian males. It found that while chronic pain was much higher among its military sample (35.6% versus 15%), “...rates of prescription pain medication use among those reporting chronic pain [was] lower in the Army than in the random sample (7.4% versus 14.8%, respectively).”¹²⁹

(1) Effects of Medication Nationally

The use of prescription medication to treat a variety of physical and behavioral health issues has increased nationally in recent years. This has prompted some in the medical and research fields to question a potential over-reliance on medication in treating many injuries and illnesses that might otherwise respond to a variety of alternative therapies. The Secretary of Veterans Affairs, Eric Shinseki, captured this concern in his remarks during a MEDCOM Symposium in June 2011:

“Let me touch on one last point that falls into the category of the undiscussable: prescribed medications, specifically, those powerful pain medications used to treat those who are in physical or mental pain. Are we courageous enough to ask whether we overmedicate some who are struggling with physical or psychological pain? Are we courageous enough to investigate whether we sometimes solve immediate problems in a manner that, ultimately, contributes to long-term problems—a downward spiral that, for some, results in homelessness and, for others, in other negative social consequences?”¹³⁰

Whether or not contemporary treatments are characterized by an over-reliance on medication, there are second-order effects associated with the increasing ubiquity of prescription medication. These effects include the increased availability of prescription medication for recreational use, creative compliance among patients issued medication and a real potential for accidental overdose. For example, according to the Office of National Drug Control Policy, prescription opioid analgesics are the most commonly abused prescription drugs in the US, with the highest rate of abuse occurring among those between ages 18-25.¹³¹ Additionally, the National Institute on Drug Abuse reported “[n]early 1 in 12 high school seniors reported nonmedical use of Vicodin and 1 in 20 reported abuse of OxyContin.” Of those who reported using Vicodin and OxyContin, 59% of the 12th graders claimed they had received it from a friend or relative. As noted by researchers in the same article, “[t]his fact reflects the prevalence in permissive attitudes toward prescription medications.”¹³²

Perhaps the most harrowing outcome of the wide availability of prescription medication is the potential for drug overdose leading to long-term health issues and, in extreme cases, death. In fact, research indicates that fatal poisonings from prescription pain relievers alone more than tripled since 1999.¹³³ The chart at figure II-16 provides

Centers for Disease Control

and Prevention (CDC) data consistent with this finding. It depicts trends for the leading causes of death among US citizens from FY2001-09, including suicide, alcohol, homicide, drugs, vehicle accidents and firearms. Although most of these causes of death are trending sideways or even downward, drug induced deaths (green line)—including deaths resulting from prescription medications—have marched steadily upward, surpassing deaths from firearms and suicides in FY2004 and vehicle accidents in FY2009. It is surprising that drug induced deaths have surpassed traffic fatalities given the volume of traffic nationally, the inherent risks associated with driving and the vulnerability of persons involved in moving vehicle accidents. It attests to the enormous availability of prescription medication and street drugs and the increasingly permissive nature associated with illicit drug use.

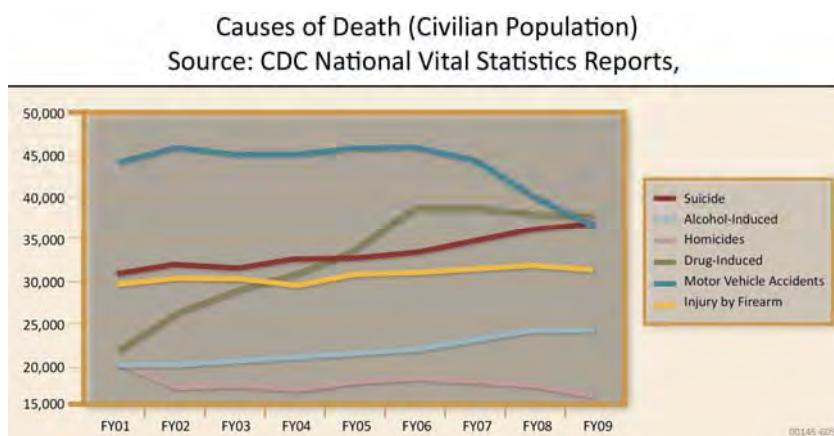


Figure II-16: Causes of Death (Civilian Population)

LEARNING POINTS

- “Nearly 1 in 12 high school seniors reported nonmedical use of Vicodin and 1 in 20 reported abuse of OxyContin.” This is a particular concern for the Army as it represents an increasingly permissive attitude among a subset within the Army’s recruiting population.

(2) Impact of Medication on the Army

The Army has also increased its use of prescription medication in the treatment of a variety of health conditions. Increases in prescription medications, as illustrated in figure II-17, for the two categories of “any type of prescription medication,” and “psychological and controlled substance prescription medications” (under the first two blue sub-headers) have been consistent year over year. For example, the Army increased the number of prescriptions for all medication from 729,312 in FY2010

to 755,354 in FY2011 and for psychotropic and controlled substances from 337,932 in FY2010 to 358,203 in FY2011. The latter category accounts for an increase in unique Soldier prescriptions (>15 days) from over 121,155 in FY2010 to 135,528 in FY2011. While all medication is prescribed by a medical care provider for treatment of physical or behavioral health issues (e.g., pain, anxiety, psychosis), the potential risks for second-order effects associated with non-compliant use, recreational use or self harm are evident.

The effects of non-compliant use are found in many research articles and can lead to long-term health issues or drug-induced death. Individuals suffering from behavioral health conditions, such as depression and anxiety, may be more likely to deviate from medical treatment plans. For example, research indicated that depressed patients are at 76% greater odds of being non-adherent with their medications than those not depressed.¹³⁴

Given the prevalence of depression among those suffering from physical or behavioral health issues, it may have a real impact on medication compliance among patients treated with multiple medications for a variety of health conditions.

The final category, polypharmacy, tracks the number of individual Soldiers who received four or more unique prescription medications with at least one of those prescriptions being a psychotropic or controlled substance. The number of Soldiers receiving a polypharmacy regimen increased 13% from FY2010-11 (141,199 to 160,175). Ostensibly this increase in multiple prescriptions coincides with patients suffering from multiple health issues but also may be due to increased numbers of different medication options, marketing, and a lack of alternative treatment options. One potential indication of this increase was highlighted in an MHAT IV (2006) versus MHAT V (2007) comparison, which found that 45% of primary care providers surveyed in MHAT IV indicated they prescribed medications for depression, while MHAT V respondents indicated 64%.¹³⁵ Nevertheless, the increased risk associated with polypharmacy is an issue at the heart of MEDCOM's pain management strategy to enhance prescription oversight using peer reviews and policy enforcement, as well as leveraging alternative pain management therapies as discussed under *Alternative Pain Management Therapies* (Chapter II, Section 3.b.(3)).

There is a growing concern among Army leaders that the upward trend in the use of prescription medication has increased the availability of drugs, which may fuel the potential for illicit drug use. This is a valid concern, given research which indicates that Soldiers—particularly young Soldiers—may have a more permissive attitude toward illicit use of prescription medications. For example, in the same research by the National Institute on Drug Abuse, researchers make the obvious connection between 12th graders and US Army accessions. When they compared drug abuse among 12th graders against the Army's FY2010 accession numbers (158,591 for AC, ARNG and USAR), researchers concluded that total

Psychotropic and/or Controlled Substance Prescription Medication		FY10 # of Patients	FY11 # of Patients
1	Number of AD Servicemembers who received a prescription medication for a psychotropic and/or controlled substance	337,932	358,203
2	Number of AD Servicemembers who received a prescription medication for a psychotropic and/or controlled substance with a supply >15 days	121,155	135,528
3	Number of AD Servicemembers who received 3 unique psychotropic and/or controlled substances with a supply >15 days	16,960	21,124
4	Number of AD Servicemembers who received 3 or more unique psychotropic and/or controlled substances with a supply >15 days	22,350	28,676
Polypharmacy		FY10 # of Patients	FY11 # of Patients
5	Number of AD Servicemembers who received 4 or more unique medications with one of those medications being a psychotropic or controlled substance	273,860	291,726
6	Number of AD Servicemembers who received 4 or more unique medications with one of those medications being a psychotropic or controlled substance with a supply >15 days	141,199	160,175

Note - A prescription medication may include a new, refill or renewed prescription for the same medication during the time period surveyed.

Figure II-17: Prescription Medication, FY10 vs. FY11

Army accessions might equate to 21,149 new recruits who previously reported illicit use of Vicodin and OxyContin. Based on AC accession numbers (74,577), they additionally extrapolated that 9,944 Soldiers in the Active Component may have illicitly used these drugs in previous years.¹³⁶ When taken together, availability of prescription drugs combined with permissive attitudes regarding their use will likely set conditions for an increase in illicit drug use and other high-risk behavior across the Force.

VIGNETTE— PRESCRIBED MEDICATIONS & THE POTENTIAL FOR ABUSE

On 24 July 2011, a 41-year-old, single SPC, with three years in the Army and one deployment, had been diagnosed with chronic back pain and was taking numerous prescribed medications. One morning he was found unresponsive in his barracks room. Interviews with unit members revealed that the SPC had been abusing his prescription medication due to his chronic pain. The post-mortem toxicology report indicated that he died from drug toxicity; he had ten separate prescription medications in his system, seven of which were prescribed. His death was determined accidental.

Polypharmacy (use of multiple prescription medications from multiple physicians or multiple medications from a single physician) can potentially set conditions for drug abuse with increasingly more dangerous outcomes.

(3) Alternative Pain Management Therapies



“We expect this effort to help us tackle the complex problems with pain, including the effective control of pain and overmedication. This will require an ambitious campaign intended to standardize pain management across the Army and a broadening of treatment approaches to provide more evidence-based choices to patients and clinicians. It has the prospect to fundamentally change the culture of pain management for our Soldiers and their Families.”

— LTG Eric B. Schoomaker
Army Surgeon General and Commander, US Army Medical Command
23 June 2010

Recognizing the increasing potential for creative compliance (abuse) or illicit use of prescription medications, coupled with a lack of standardization with respect to pain management across both military and civilian medical communities, the Army chartered the Army Pain Management Task Force (PMTF) in August of 2009. The PMTF, under the direction of The Surgeon General and Commander, MEDCOM, was chartered to review current pain management practice across the Army and make recommendations for a comprehensive pain management strategy. The PMTF was comprised of subject matter experts from the Army, Navy, Air Force, TRICARE Management Activity and VA and collaborated with existing pain-related initiatives in the Army, DoD, VA and civilian medicine.

The PMTF Final Report, published in May 2010, reflects almost a year of study conducted by the task force. The report contains 109 recommendations for a pain management system that is holistic, interdisciplinary and multimodal in its approach; utilizes state-of-the-art / science modalities and technologies; and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.¹³⁷ MEDCOM is continuing to implement the recommendations through the Army Comprehensive Pain Management Campaign Plan. Recommendations include: (1) interdisciplinary pain management centers which, in addition to pain physicians, would include other healthcare professionals, such as an

acupuncturist, clinical pharmacist, chiropractor, medical massage therapist, neurologist and physical and occupational therapists;¹³⁸ (2) a new Defense and Veterans Pain Rating Scale that adds descriptions of each pain level to help patients more accurately assess and report their degree of pain; and (3) a Pain Management Survey that would standardize measurement across the DoD and VA continuum, enabling the identification of best practices and accurate measurement of progress when implementing pain management strategies.

The intent of the Army's calculated shift from medicating pain to managing pain is to provide Soldiers and other patients with effective relief from acute and chronic pain without further contributing to the complexity or severity of individuals' conditions. One of the most significant advantages of alternative pain therapies, as compared to the use of prescription drugs and narcotics, is reduced side effects. There is obvious appeal in finding and employing treatment methods or techniques that are considered low risk, while also proving to be effective. As such, the Army has begun to employ a broader range of techniques or methods of therapy, including complementary and alternative modes such as yoga, meditation, hypnosis, acupuncture and biofeedback. Among the new therapies being tested is Qigong, a form of Chinese meditation consisting of deep breathing exercises intended to reduce stress. Advocates say Qigong lowers blood pressure and blood sugar levels. Exploration of other pain strategies continues. These alternative pain management strategies are novel approaches for the Army medical department and their effectiveness is still being evaluated.

VIGNETTE—ACUPUNCTURE

A SFC used to jog, walk, lift weights and ride her Harley-Davidson Fat Boy, the motorcycle she bought after serving in Iraq. Today, she suffers from scleroderma, a painful and potentially fatal disease. She feels pain in her face, joints and toes. She's lost some of her hair and her toenails fell off. "It's to the point I want them to deaden the nerves in my face. But [the doctor] said if you do that you take a chance of developing muscle atrophy, Bell's palsy with the real bad facial droop, no muscle control. I said I'm willing to take my chances. Just do something about it. It's just consumed me, and I'm miserable." An orthopedic physician's assistant performed an acupuncture treatment, injecting small gold needles into selected parts of her ear and, at least for her, it appears that the treatment is providing some relief. "This is the first time I ever tried acupuncture because I used to laugh at it. I'd be looking on the TV with the Chinese with all those needles and the person looking like a porcupine. I used to laugh at it, I did. And not now. Not now."

LEARNING POINTS

- ★ The Army is employing a broader range of techniques or methods of therapy, to include complementary and alternative modes such as yoga, meditation, hypnosis, acupuncture and biofeedback.

(4) Policy and Programs

The Army has made real progress in mitigating risks associated with the increased use of prescription medication. The Office of the Surgeon General (OTSG) tracks and monitors prescription medication issuance and use across the Force. It sharpened its focus on polypharmacy data following the publication of the *Red Book*. It specifically defined polypharmacy as four or more unique medications (with one being a psychotropic or controlled substance) prescribed to patients by more than one healthcare provider for the treatment of multiple conditions.¹³⁹ This definition recognizes the heightened risks associated with polypharmacy based on both the number of healthcare providers and

unique medications involved in the treatment. MEDCOM published risk mitigation measures in its Policy Memorandum 10-076, 9 November 2010. This memorandum clearly emphasized the importance of mitigating the effects of polypharmacy:

The Army Suicide Prevention Task Force has identified polypharmacy as a contributing factor in suicides, fatal accidents and other adverse outcomes among Army personnel. As combat operations continue, more Soldiers are presenting with physical injury, psychological injury, or both, which require medication therapy. Consequently, some Soldiers may be treated for multiple conditions with a variety of medications prescribed by several healthcare providers. The resulting polypharmacy can place Soldiers at increased risk for adverse clinical outcomes.

This risk warning was based on the findings of the *Red Book*, which posited two key recommendations that underpin MEDCOM's policies for the Army at large and the Army's WTU population (OTSG / MEDCOM Policy Memorandums 10-076, 9 November 2010 and 11-029, 7 April 2011):

- Establish a quality assurance and peer review policy by which “at-risk medication” prescriptions are tracked when more than two psychiatric / psychotropic medications are prescribed. (MEDCOM response, Policy Memorandum 10-076)
- Draft policy and develop a system / program to periodically evaluate WTU Soldiers with prescriptions to determine potential abuse / dependence. (MEDCOM response, Policy Memorandum 11-029)

Additionally, the policy calls for 30-day limits on new prescriptions and comprehensive reviews of cases where patients are receiving four or more drugs. These and other important changes may lead to a decrease in the use of prescription medications (specifically narcotics and psychotropic medicines) across the Force.¹⁴⁰

While the Army and the military medical community have made tremendous progress in the area of comprehensive pain management, there is still much work to be done. According to the American Academy of Pain Medicine, “pain medicine is a relatively new medical specialty that is evolving along with its place in the medical hierarchy.”

With respect to prescription drug use, the PMTF has created new policy guidelines to ensure fewer Soldiers are able to become addicted to prescription drugs. Among the most notable, MEDCOM Regulation 40-51 established policy for physicians, nurse practitioners, physician assistants, and toxicologists assigned duties as Medical Review Officers (MRO) in determining if a medical explanation exists for a positive urinalysis drug testing result. ALARACT 062 / 2011, issued on 23 February 11, changed the length of authorized duration of controlled substance prescriptions, as addressed in MEDCOM Regulation 40-51, to six months from date of dispensing.¹⁴¹ The background regarding these two policies is discussed under *Drug and Alcohol Abuse* (Chapter II, Section 2.d.).

Further progress has been made over the past year with respect to tracking prescription drug use. Prescription records for Soldiers are now tracked by Defense-wide electronic databases. Additionally, as a part of mitigating the ubiquity of pain narcotics and other controlled drugs, the Army has requested permission through the DoJ and DEA to implement prescription medication take-back programs at medical treatment facility (MTF) pharmacies. The goal is to reduce the amount of unused controlled

medications in the Force; decrease the non-medical use of prescription medication; and decrease the potential for accidental overdoses related to unauthorized use of controlled medication. This initiative would allow individuals with unused or expired medications to turn them back to Army control for appropriate disposition.

Finally, policies and programs governing Army pain management will continue to develop as recommendations from OTSG / MEDCOM campaign plans are implemented, and as advances in medical science unfold. The Army, in coordination with the VA, DoD and the other Services, has made tremendous gains to keep up with the impact of over a decade of war on such a large military population. To be sure, the Army will be challenged to provide effective medical care for increasing numbers of Soldiers requiring near and long-term pain management, while developing proactive policies to reduce potential risk associated with this medical care. Nevertheless, Army policy governing pain management remains one of the most prolific areas of improvement within the Army's Health Promotion & Risk Reduction portfolio.

LEARNING POINTS

- The Army will be challenged to provide effective medical care for increasing numbers of Soldiers requiring near and long-term pain management, while developing proactive policies to reduce potential risk associated with this medical care.

c. Suicide

“We can identify those individuals with highest risk for suicide, but we can’t identify those who will commit suicide in the near future. In part, this is because the duration between the suicidal thought and attempt is usually about 10 minutes.”¹⁴²

— Dr. Igor Galynker, MD, PhD
American Psychiatric Association Meeting, May 2011

Suicide is perhaps the most complex—and severest—outcome of comorbidity and life stressors. It certainly adds tragic weight to the complexity of surveillance, detection and response for commanders weighing potentially innumerable indicators (symptoms and behaviors) in determining their appropriate response. Each potential suicide or attempted suicide is different with respect to contributing factors and triggering events. Each victim responds differently to pre-suicide stressors based on protective factors such as personal resilience, coping skills, and whether or not they are help-seeking. Therefore, the cues they provide participants in the health triad are as unique as the individuals themselves. To be sure, the Army has investigated numerous suicide cases that, in hindsight, seemed to present a clear trail of behavioral indicators that may have afforded leaders or others in the social circle an opportunity to respond. However, post-mortem suicide investigations can never truly capture the subtlety of pre-suicide indicators nor truly judge the appropriateness of the response within the pre-suicide context—a context where innumerable outcomes can lead to innumerable interpretations.

(1) Suicide as a National Issue

CDC analysis of national data continues to lag Army suicide reporting by approximately two years; no data estimates or analysis is available for either CY2010 or CY2011. The CDC's most recent report, reflecting preliminary data from CY2009, indicates that there were approximately 36,547 suicides in that

year, equating to one suicide approximately every 15 minutes. Based on this preliminary data from CDC the national suicide rate has subtly increased from 11.8 per 100,000 in CY2008 to 11.9 in CY2009. In fact, CDC reported that of the 15 leading causes of death in CY2009, suicide was the only cause of death that moved up the list from the 11th leading cause of death in CY2008 to the 10th in CY2009.³ Perhaps more surprising, suicide as a manner of death surpassed vehicle fatalities nationally in CY2009 and has consistently more than doubled national homicide totals year over year.¹⁴³ Its impact is felt in every measurable way—estimates suggest that for every 1 suicide, 6 people are significantly adversely impacted.¹⁴⁴ Or as the American Association of Suicidology put it, the US had collectively lost over 1,043,591 years of potential life due to suicide in CY2008.

When demographically adjusted for the Army population (age, gender and race), the national suicide rate is expected to slightly increase from 17.7 per 100,000 in CY2008 to 18.6 in CY2009.¹⁴⁵ The published suicide rate for CY2008, adjusted by the US Army Institute of Public Health, has a 95% confidence interval between 14.1 per 100,000 and 21.3. In other words, due to a small suicide population, the demographically adjusted national suicide rate for CY2008 could range from a statistical point significantly lower than the Army suicide rate to a point more on par with the Army suicide rate (but is likely to be similar to that of CY2008). The demographically adjusted national suicide rate has not been determined for CY2009.

The overall national suicide rate has steadily increased since CY2000, forming a V-pattern from CY1993-2008 (figure II-18). Based on the suicide rate of 11.8 per 100,000 in CY2008

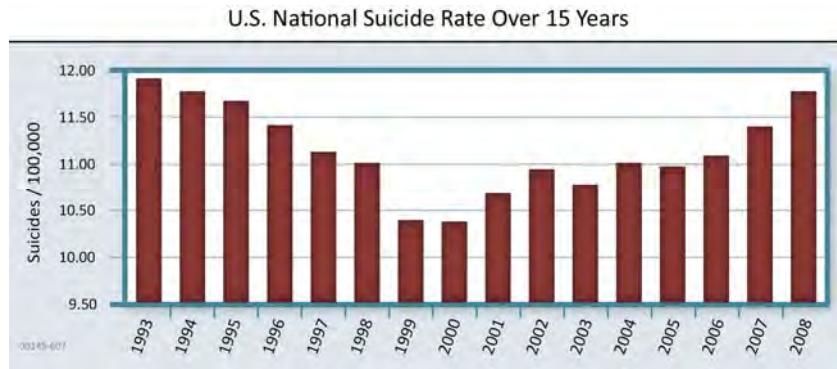


Figure II-18: National Suicide Rate

and preliminary findings of 11.9 in CY2009, the suicide rate appears to be closing in on its 15-year high set in CY1993. One explanation for this V-pattern may be the US economy, with suicides correlated to national growth and recession cycles (e.g., growth 1999, recession 2001). According to a CDC report, there is a significant link between "...business cycles and suicide among working ages 25-65."¹⁴⁶ This may also explain changes in suicide rates for the 45-54 and 55-64 age categories which have risen from 14.8-18.7 and 13.1-16.3 per 100,000 (respectively) from CY1998-2008. This relationship and its impact on the Army are discussed further under *Impact of Suicide on the Army* (Chapter II, Section 3.c.(3)).

American Association of Suicidology analysis of CDC data for CY2008 generally parallels Army suicide demographics and suicide event factors. For example, white males continued to lead all major demographic categories at 21.2 per 100,000. Female suicide numbers were lower than males, with one female suicide for every 3.75 male suicides. Preferred methods of suicide among the US population also parallel the Army as enumerated in the following order: 50.6% firearms; 23.8% hanging / suffocation; 17.9% [drug / alcohol] poisoning; and 7.7% other. Also, although there is no national database for suicide attempts, estimates placed suicide attempts at approximately 900,875 attempts per year or about one every 35 seconds. There is an estimated 25 attempts for every completed suicide, with females attempting suicide three times more often than their male counterparts.¹⁴⁷

³ The subtle increase in suicides is less a factor in its move to the 10th leading cause than septicemia's statistically significant decrease, moving it from the 11th to the 10th position.

A meta-analysis covering multiple suicide studies implicated behavioral health disorders and, in particular, comorbidity as a major contributing factor. It found that “[p]sychological autopsy studies reflect that more than 90% of completed suicides had one or more mental disorders.” Its findings highlighted the fact that individuals with depression, schizophrenia, drug and / or chemical dependency and conduct disorders among youth place them at higher risk for suicide. More specifically, research findings suggest that depression coincides with suicide in approximately 50-60% of all cases.¹⁴⁸ Research among young people ages 10-30—bracketing a major Army demographic—found that among 894 suicides, 88.6% had one or more behavioral health disorders. “Mood disorders were most frequent (42.1%), followed by substance-related disorders (40.8%) and disruptive [conduct] behavior disorders (20.8%).” Finally, the meta-analysis concluded that alcohol abuse and illicit drug use places individuals at 8.5 and 10.1 times higher risk for suicide.¹⁴⁹

(2) Suicide among Military Veterans

Although the Army’s suicide rate clearly exceeds the national rate, the lag in national suicide reporting continues to hinder comparative analysis of recent US and Army suicide data. Nevertheless, national data from prior years, including other research reliant on CDC data, provides some insight into service-related suicides. According to the VA, veterans composed 20% of these suicides with approximately 18 veterans killing themselves daily; five of whom were enrolled under VA care. Three of five veterans enrolled who committed suicide were patients with a known mental health condition.¹⁵⁰ On a related note of equal concern is the fact that approximately 950 veterans under VA care attempted suicide each month between October 2008 and December 2010.¹⁵¹

Also, suicide rates among OIF / OEF veterans enrolled in VA care, regardless of treatment status, were higher than both civilian and active duty Servicemembers per 100,000 from FY2006-08. This cohort of male and female veterans experienced rates of 26, 28 and 38 per 100,000 compared to civilian rates ranging from approximately 18.7, 18.9 and 17.7 (demographically adjusted) and active duty rates ranging from approximately 14.9, 16.8 and 19.6 for the same years.⁴ Male veterans led all cohorts with rates per 100,000 of 30, 30 and 43.¹⁵² Additional research indicates that OIF / OEF veterans in general are at higher risk for suicide immediately following transition from active duty, with risk decreasing across time. Following separation from active duty, veteran suicide rates were 23.1 per 100,000 in the first two years, 18.1 in years two through four and 12.9 in years four through six.¹⁵³ Recent research may provide new insight into higher suicide rates among veterans and active duty Soldiers. Research in 2010 concluded:

Interpersonal-Psychological Theory of Suicide proposes three necessary factors are needed to complete suicide: feelings that one does not belong with other people, feelings that one is a burden on others or society, and an acquired capability to overcome the fear and pain associated with suicide; findings suggest that although there are many important factors in military suicide, the acquired capability may be the most impacted by military experience because combat exposure and training may cause individuals to get used to fear of painful experiences.¹⁵⁴

In a study of military personnel deployed to Iraq, research indicated that increased combat experience could predict “...an acquired capability above and beyond any of the following: depression, PTSD symptoms, previous suicidality, and other common risk factors for suicide.”¹⁵⁵ Additional research

⁴ Fiscal year rates are extrapolated from calendar year data.

concluded that, in general, combat exposure increased individual risk for suicide but, in particular, combat associated with higher levels of violence, injury and death affected the “acquired capability” by desensitizing the individual to fear of painful experiences.¹⁵⁶

Also, recent research along more traditional lines of inquiry continues to implicate comorbidity in increasing the risk for veteran and Soldier suicides. For example, in one study, 167 OEF and OIF veterans seeking primary or behavioral healthcare completed surveys measuring a range of risk factors including combat exposure, behavioral health and pain management as well as protective factors including resilience, social support, and coping strategies found that an astounding 22% or 37 veterans contemplated suicide in the two weeks preceding the survey. Those most at risk were “...older, and more likely to screen positive for depression and PTSD, and to report a deployment-related pain condition or complaint. They also scored higher on measures of worry, self-punishment, and cognitive behavioral avoidance strategies, and lower on measures of psychological resilience and post-deployment social support.”¹⁵⁷ A second study a year later (2010) supports this finding, citing that those contemplating suicide were more likely to suffer from symptoms of PTSD, depression, and alcohol abuse. They also concluded that these veterans were less psychologically resilient and had smaller social support networks, suggesting that “buffers against suicidal ideation were increased social support and feelings of control.”¹⁵⁸

(3) Impact of Suicide on the Army

The active duty Army suicide rate steadily increased between CY2004 and CY2009 from approximately 9.6 per 100,000 to 21.9 per 100,000 (red line at figure II-19), surpassing the demographically adjusted national suicide rate for the first time in CY2008 (black line).¹⁵⁹ Although the Army active duty rate has slowed since CY2009, suicides have continued to increase with a projected high of approximately 24.1 per 100,000 for CY2011.

Pending actual suicide numbers for CY2011,

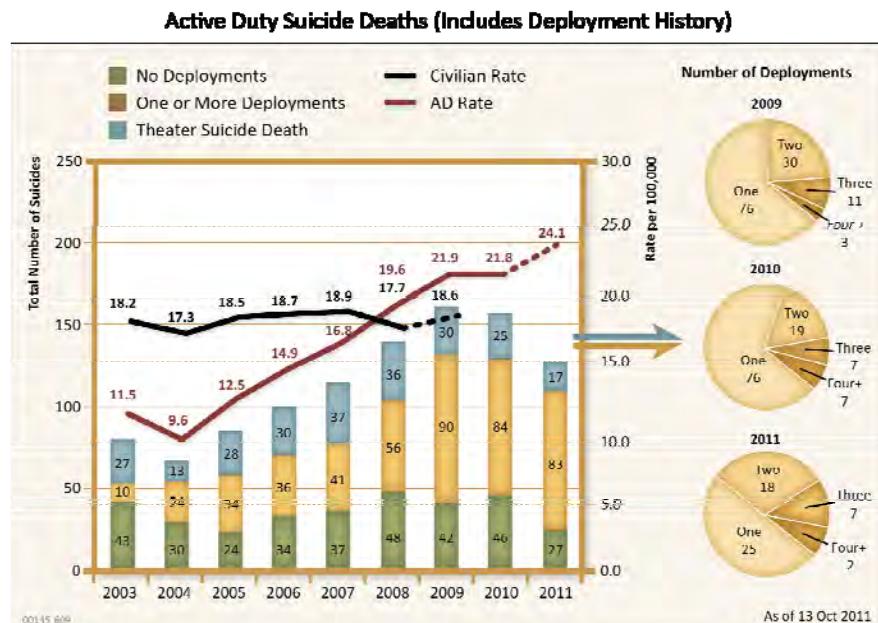


Figure II-19: Active Duty Suicide Deaths

suicide and suicide attempts from CY2009-10 appear somewhat optimistic. Numbers for both suicide and suicide attempts declined from 162 AD suicides (244 all COMPOs) and 1,679 known attempted suicides in CY2009 to 155 AD suicides (300 all COMPOs) and 1,079 known attempts in CY2010. In fact, suicide attempts, defined by emergency room visits, demonstrably decreased by 35% in a single year.

The relationship between suicide and deployments appears to have changed significantly in CY2009. The pie charts at figure II-19 provide the deployment status for Soldier suicides from CY2009-11, which indicate a decrease in the pattern of one-time deployers or an increase in the pattern of multiple

deployers who committed suicide. The percentage of total suicides by one-time deployers decreased from 63% in CY2009 and 69% in CY2010 to 50% in CY2011. This is also true for the suicide set of Soldiers who either never deployed or deployed only once with a decrease from 73% in CY2009 and 78% in CY2010 to 61% in CY2011. This change in deployment-suicide patterns was unaffected when adjusted for Soldier retention because of the high turnover in junior enlisted Soldiers. The Health Promotion and Risk Reduction Task Force is currently analyzing this change based on three questions: (1) “Has increased emphasis in zero / first time deployers ‘squeezed the balloon’ to transfer risk from infrequent to repeated deployers?”; (2) “Do repeated deployments place Soldiers at higher risk for Suicide?”; or (3) “Are economic factors discouraging individuals, already stressed by deployments, from leaving the Service?” All three questions may address the larger issue that repeated deployments may cause cumulative stress further impacting a population at risk for suicide

As of the close of FY2011, Army suicide prevention efforts reflect varying results with a decline in AD (all COMPOs) suicides, ARNG suicides and Civilian suicides but an increase in USAR and Family member suicides. The chart at figure II-20 provides Army AD, USAR, ARNG, Family Member and Civilian suicide numbers for fiscal years FY2008-11. Although the AD suicide numbers are relatively fixed due to a stable, tight reporting cycle, all other suicide populations are expected to adjust upward based on lag reporting between the closeout of this report and final reporting and manner of death determination. Preliminary results of suicide reporting among the AD and ARNG (tentatively) trended downward from FY2010-11, with ARNG reversing its steep incline of 88% from FY2009-10 by a 13% decline from FY2010-11. Both the Army Reserve and Family Member populations continue to show an increase in suicide rates from FY2008-11.

The true impact of Army suicide prevention efforts is unknown; like any prevention program, it can be hard if not impossible to measure its effectiveness. What is known is that Army populations—all COMPOs, Families, Civilians and veterans—are under increased stress after a decade of war (see *Stress*, Chapter II, Section 2.e.). Increased stress from war-related OPTEMPO, health issues, Family separations, economic and employment pressures have likely reached a multi-decade—and generational—peak, which if not for Army suicide prevention efforts, may have potentially doubled, tripled or even quadrupled the Army’s current suicide rates.

Army Suicides, FY08-11					
	FY08	FY09	FY10	FY11	Δ FY10-11
Active Duty*	137	159	164	162	-2
Army Reserve**	17	32	32	38	6
National Guard**	45	48	90	78	-12
Family Members	4	8	11	15	4
Civilians	Data Not Available	18	29	28	-1
Total	203	265	326	321	-5

* Includes Army Reserve and National Guard Soldiers on Active Duty

** Non-Mobilized USAR and ARNG Soldiers

00295-012

Figure II-20: Army Suicides, FY08-11⁵

⁵ Fiscal year data were used in this figure to close out suicide numbers for FY11, concurrent with the timing of this report.

VIGNETTE— NCO RELIES ON TRAINING TO PREVENT SUICIDE¹⁶⁰

A SSG observed a Soldier attempting to purchase cigarettes without his ID at a Fort Hood shoppette. The SSG detected the odor of alcohol and suggested the Soldier leave. The Soldier then asked him if he could speak with him once he (the SSG) was done with his purchase. The SSG quickly noticed the Soldier looked rough as if he had been in a fight. The Soldier kept telling him that he “was done.” When the Soldier stated “I just reenlisted, but I’m done, if you know what I mean,” the SSG realized what the Soldier was implying, knew he required help and quickly called upon his Ask, Care and Escort (ACE) training. He contacted the Military Police and safeguarded the Soldier until they arrived.

In October 2011, the SSG was commended by the CG, III Corps and Fort Hood, who stated “It is because of [his] quick actions that a Fort Hood team member is getting the help he needs and deserves....we must all have the courage to help a buddy.” The SSG commented, “I had a job to do and somewhere to go, but in the end, I’m glad I stuck around to talk to this individual. If your battle buddy is hurting in any way, you know how to go out and get him some help.”

LEARNING POINTS

- Although the Army active duty rate has slowed since CY2009, suicides have continued to increase with a projected high of approximately 22.9 per 100,000 for CY2011.

(4) Army Suicides Compared with Other Services

Over the recent years, Army AD and Marine Corps suicide rates have led the other two Services from CY2001-10 (figure II-21). It is expected that this trend will prove true for CY2011. Additionally, the Army has experienced the longest sustained increase in suicide rates from CY2004-09 with a subtle decline in CY2010. Although the Army and Marine Corps generally experienced parallel rates, the Marine Corps experienced a notable reduction in its suicide rate from CY2009-10. Analysis as to the potential cause for this decline is still under consideration. Nevertheless, both Army and Marine Corps still remain higher than the Navy and Air Force, which may be a reflection of combat-related stress (e.g., greater incidence of behavioral health disorders, longer family separations).

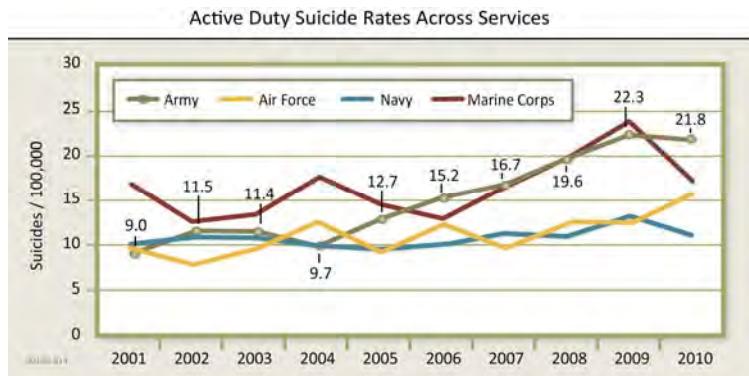


Figure II-21: Active Duty Suicide Rates Across Services¹⁶¹

(5) Army Awareness of Risk Factors

The Army reported Service-specific suicide and suicide attempt stressors into the DoDSER for CY2010, which generally mirror other Service information. The chart at figure II-22 provides stressors across 12 broad categories in descending order of prevalence as it relates to suicides, notwithstanding some differences in the prevalence of stressors between suicide and suicide attempts. These categories

are not mutually exclusive, meaning a single victim could be affected by multiple stressors. Military work stress, relationship problem, legal history and victim of abuse were leading stressors followed by other trailing stressors as depicted in the chart.

Military work stress replaced relationship problems in CY2010, which had previously led all stressors from CY2003-09. Additional Army DODSER information regarding the most prevalent (known) suicide and suicide-attempt related stressors in CY2010 is provided below:¹⁶²

- Suicide and suicide attempt demographics for the Army mirrored all Services, as described previously.
- The most common suicide mechanisms were firearms (68%), hangings (21%) and drug overdoses (4%); for suicide attempts they were drug overdoses (58%), sharp / blunt objects (12%) and hangings (8%).
- Similar to all Services, suicide victims did not generally communicate their intent (67%); those who did, communicated with spouses and friends (16%). The majority of suicide attempts did not communicate their intent (86%); those who did, also communicated with family and friends (10%).
- The location of suicides were personal residence or barracks (53%); residence of friend / family (13%) and work / jobsite (7%). The location of suicide attempts were personal residence or barracks (81%) and automobile, away from residence (5%).
- Known financial pressures only highlighted excessive debt / bankruptcies (12%) for suicide and suicide attempts. Anecdotally, this number may be significantly underreported as finance can be a co-stressor with other stressors such as failed relationships and work-related issues. Additionally, Army metrics still do not separate financial loss from actual financial debt.
- Work stress (comprised of job loss / instability, supervisor / coworker issues, poor work evaluation and unit / work place hazing) was associated with 47% of the suicides and 84% of the suicide attempts. The majority of work-related stress affecting suicide was job loss / instability (21%) and poor work evaluation (14%) for suicide; job loss / instability (34%) and supervisor / coworker issues (25%) for suicide attempts.
- Failed relationship (intimate or other) was associated with 49% of the suicides (29% within the last 30 days) and 60% of the suicide attempts (38% within the last 30 days).
- Behavioral health issues (comprised of mood and anxiety disorders) were associated with 46% of the suicides (29% of the victims had at least two co-occurring diagnoses) with specific diagnoses of mood disorders (18%) and anxiety disorders (16%). Behavioral health issues were associated

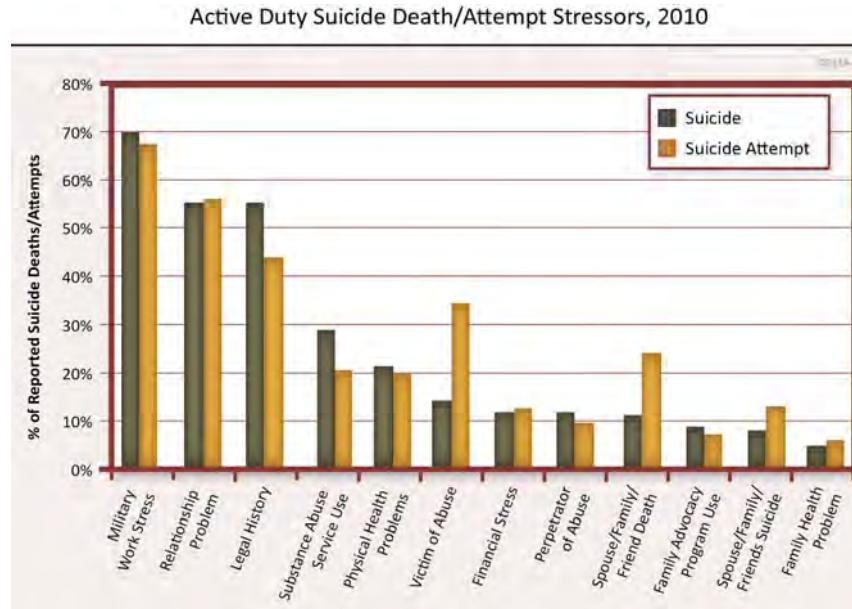


Figure II-22: Active Duty Suicide Attempt and Death Stressors

with 65% of the suicide attempts, with specific diagnosis of mood disorders (39%) and anxiety disorders (28%).

- Legal and administrative issues (comprised of court-martial, Article 15, administrative separation, AWOL, medical board, civil legal problems, and non-selection for promotion) were associated with 44% of the suicides and 43% of the suicide attempts. The top two stressors for suicides and suicide attempts were Article 15 (21%) and civil legal problems (14%), and Article 15 (19%) and administrative separation (13%), respectively.
- Treatment history (comprised of outpatient behavioral healthcare, inpatient behavioral healthcare, physical health problem, substance abuse, and family advocacy issues) associated with suicide includes: outpatient behavioral healthcare (65 suicide victims or 44%) of which 60% were within the last 30 days; inpatient behavioral healthcare (18 or 12%) of which 50% were within the last 30 days; physical health problem (27 or 18%) of which 70% were within the last 30 days; substance abuse (35 or 24%) of which 34% were within the last 30 days; and family advocacy issues (9%). Approximately 37% of those who committed suicide were seen at a military treatment facility within 30 days of the event. Suicide attempts associated with treatment history included: outpatient behavioral health care (275 attempted suicide victims or 67%), of which 45% was within the last 30 days; inpatient behavioral health care (103 or 25%), of which 40% were within the last 30 days; physical health problem (89 or 22%), of which 61% were within the last 30 days; substance abuse (80 or 19%), of which 50% were within the last 30 days; family advocacy issues (7%). Approximately 34% of those who attempted suicide were seen at a military treatment facility within the 30 days preceding the event.

However, Information from the Medical Data Repository's medical claims data in the Army Behavioral Health Integrated Data Environment system from 2001-2011 adjusts treatment history for suicide victims upward, reporting that 891 (78%) of the 1,141 total suicide victims had a behavioral health encounter during their military career. Also, 669 (59%) of the 1,141 had a behavioral health encounter in the year prior to their suicide with 329 (29%) of those encounters occurring within the last 30 days.¹⁶³

- Known history of psychotropic medication use prior to suicide (29%) included antidepressants (22%), antianxiety (10%), antipsychotics (5%), anticonvulsants (3%) and antimanic (1%). Known history of psychotropic medication use prior to suicide attempts (48%) included antidepressants (39%), antianxiety (20%), antipsychotics (8%), anticonvulsants (2%) and antimanic (3%).
- History of substance abuse associated with suicide and attempted suicide was 28% and 24%. Known drug and alcohol use during the suicide event included drugs (9%), alcohol (22%) and both (4%); unknown use of drugs (46%) and alcohol (39%). Known drug and alcohol use during the suicide attempt included drugs (63%), alcohol (30%) and both (21%).

One additional stress factor analyzed by the HP&RR Task Force was with respect to suicide triggers, which identify the last known stressor immediately prior to the suicide event. The intent of identifying a suicide trigger is to recognize the potential "last straw" prior to the suicide without respect to its severity or contribution to the victim's cumulative stress. Triggers were identified in approximately half of all suicide events from FY2007-11 (47%); identified triggers included failed relationship (37%); work problems (21%); legal / UCMJ (16%); and financial (6%). The Task Force's analysis also noted use of alcohol (19%) and / or drugs at the time of death (8%).

(6) Hospitalization for Suicidal Ideation

According to the Medical Surveillance Monthly Report, treatment and care for active duty Servicemembers with suicidal ideation, as measured by hospitalization, has increased by an average of

~600 year over year from 2005-10 (figure II-23). This increase in hospitalization is comprised of patients with both a primary (355) and non-primary (~3,200) diagnosis for suicidal ideation. Although patients with non-primary diagnosis make up the vast majority of hospitalizations, both patient categories are collectively approaching

4,000 hospitalizations across all Services.¹⁶⁵ At the current rate of increase, DoD can expect to have over 4,500 suicidal ideation-related hospitalizations by the end of 2011. This means that for every five Active Component Servicemembers who commit suicide there are at least six who are hospitalized primarily for suicidal ideation and almost 64 others hospitalized who are affected by suicidal ideation. If interpolated to the AC Army population (based on respective suicides), this would mean that for every Army suicide more than 12 Soldiers were hospitalized in 2010 with a primary or non-primary diagnosis of suicidal ideation.⁶

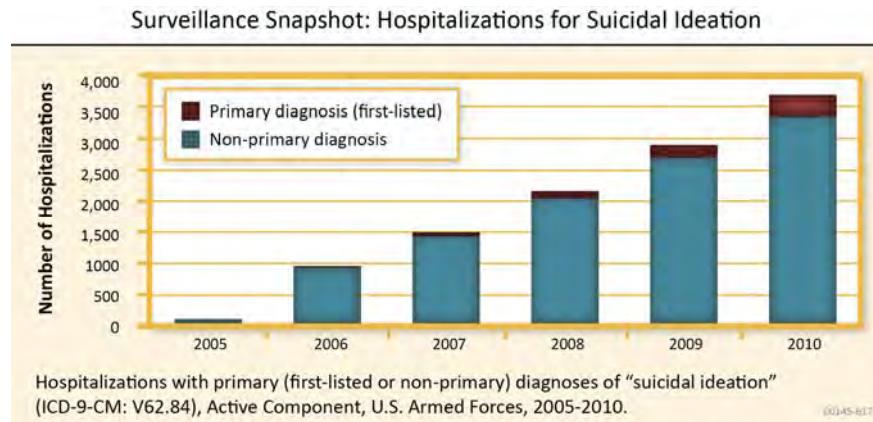
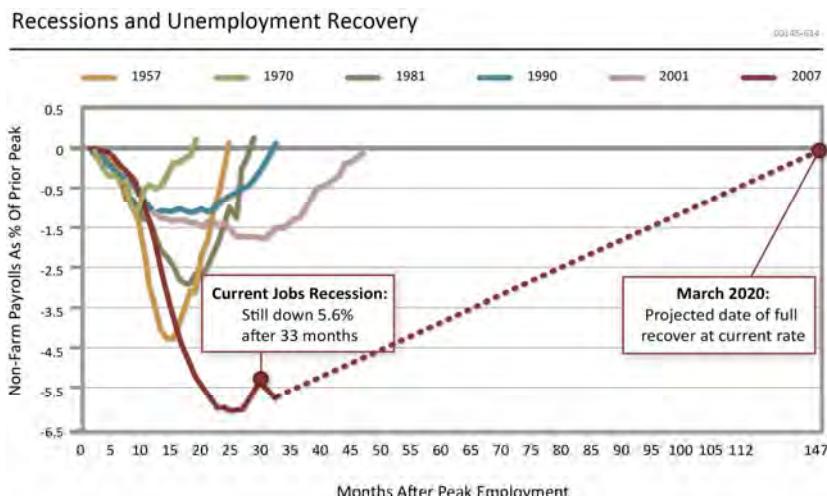


Figure II-23: Hospitalizations for Suicidal Ideation¹⁶⁴

(7) Economic Stressors Affecting the Reserve Component

The US economy continues to teeter on the brink of yet another recession as recurring economic indicators (e.g., jobs report, consumer confidence, earnings report, market indices) struggle to find positive momentum. Arguably the most devastating economic impact has been the sharp increase in unemployment, which has hovered around 9% since CY2009. There are currently over 14.0 million people unemployed, with over 6.2 million characterized as long-term unemployed (> 6 months). This category accounts for 44.6% of all unemployed US citizens.¹⁶⁷ Moreover, “[u]nderemployment, a measure that combines the percentage of workers who are unemployed with the percentage working part time but wanting full-time work, was 18.5% in mid-September [2011].”¹⁶⁸



The current job recession is unprecedented. Compared with other post-WWII downturns, employment has fallen much more, and recovery is taking much longer. At this year's rate of job growth, employment won't return to its prior peak until March 2020.

Figure II-24: Unemployment Recovery¹⁶⁶

⁶ Interpolation based on 140 AC Army and 295 AC Service suicides.

The projections for economic recovery are much worse. The chart at figure II-24 provides an overview of unemployment recovery in each of the major recessions since WWII. It reflects both the percent unemployed and the time in months from the onset of each recession until employment returned to its pre-recession levels. Simply stated, it reflects the depth and duration of unemployment during each recession. In most recessions (1957, 1970, 1981 and 1990) unemployment trends formed a buttonhook pattern, with unemployment quickly returning to its pre-recession levels. The obvious counterexample is the 2007 recession (December 2007 - June 2009) and perhaps the 2001 recession, lasting almost twice as long as those in prior years. The Goliath among these economic periods, however, is the 2007 recession. It not only reflects the highest unemployment but, more crucially, is not projected to return to its pre-recession levels until approximately March 2020—13 years from its onset. More unfortunately, other research questions whether or not the US will ever return to its 2007 pre-recession employment levels. In essence, the two largest recessions impacting unemployment book-ended the war, financially squeezing RC Soldiers between deployments and a fragile labor market.

By all indications, ARNG and USAR Soldiers have been and continue to be more affected by poor economic conditions than AC Soldiers who are more insulated from economic and, more particularly, employment considerations. (It is worth noting that the AC military is so insulated that it is not even included in US labor

employment numbers or statistics.) National data (figure II-25) show that young veterans (including RC Soldiers), ages 18-34, were more likely to be unemployed than non-veterans. In CY2010, average unemployment for ages 18-24 and 25-34 was approximately 21% and 13%. And these numbers were likely underreported because of deployments and other temporary Service-related employment.

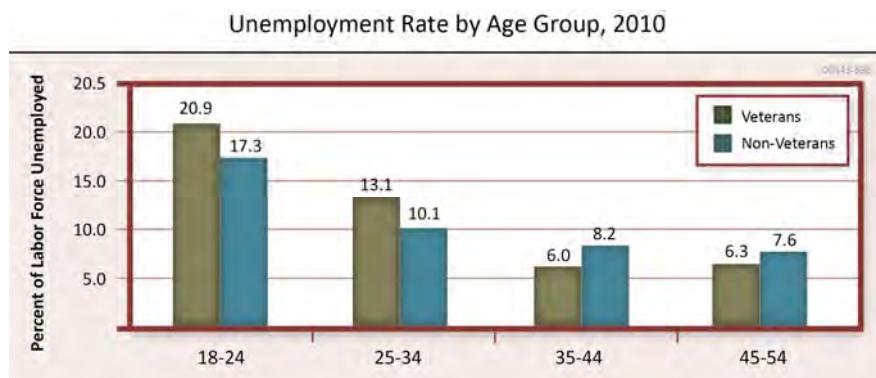


Figure II-25: Unemployment Rate by Age Group¹⁶⁹

The protracted nature of the current recessive employment environment, coupled by the fact that external stressors are not easily mitigated, has left RC Soldiers and veterans to contend with economic stressors. There is little doubt that the on-again, off-again effect of repeated mobilizations has also measurably increased employment stress as they have come and gone during a decade of war. This stress may be the catalyst behind the significant increases in suicides and suicide attempts among ARNG and USAR Soldier populations from FY2009-10. Research regarding the relationship between financial pressure and suicide has consistently found a strong correlation between economic conditions and suicide; suicides increase during financial crisis. In a study of three cohorts comprising 26,330 subjects, researchers demonstrated that people with lower socio-economic status or who are unemployed are 2.2 times more likely to die by suicide than those in a higher socio-economic status or those who are employed.¹⁷⁰ Also, in a large pan-Euro study, researchers examined World Health Organization data from ten countries as unemployment increased by approximately one-third from CY2007-09. They found that economic downturns "...almost certainly resulted in increased suicides among working age Europeans..." Suicides increased in nine of ten countries from 5%-17%. They noted that suicide rates, which were retreating prior to the recession, started increasing in almost all of the countries studied. They ultimately concluded that "...unemployment or the risk of it poses significant challenges to mental health."¹⁷¹

The chart at figure II-26 provides compelling evidence that unemployment rates may potentially move [in cycles] with suicide rates. When the US unemployment rate was superimposed over the national suicide rates from CY1993-2009, it closely mirrored suicide rates across time. This compelling relationship

can prompt some chilling conclusions about the potential impact of financial stress, in terms of severity and duration, on the RC and veteran populations—especially given the potential drawdown and reduced opportunities for military employment as the Army transitions to peace. This potential cause and effect relationship also may have implications among disabled Soldiers and veterans, whose physical or behavioral health issues may disadvantage them during employment. At a minimum, the Army must continue to assess and mitigate the potential impact of employment and financial stress on RC Soldiers, as well as those Soldiers transitioning to civilian employment. This conclusion is supported by the fact that “44% of veterans who served in the past decade called the transition back to civilian life difficult—nearly double the rate of veterans who served before them.”¹⁷³

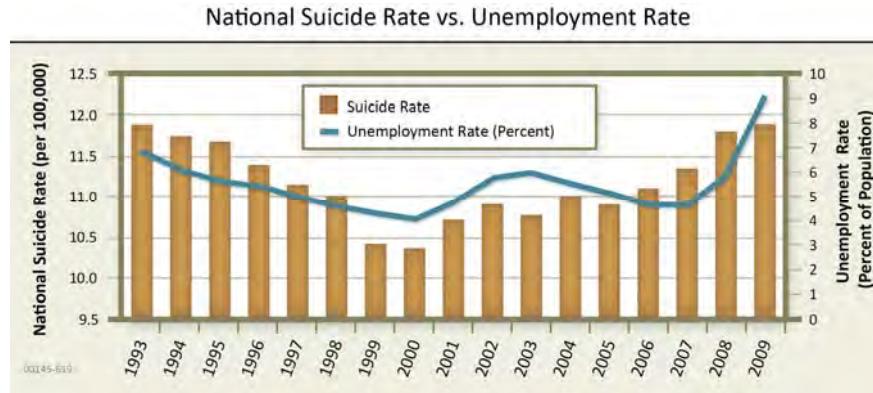


Figure II-26: Suicide Rate vs. Unemployment Rate¹⁷²

LEARNING POINTS

- ★ At the current rate of increase, DoD can expect to have over 4,500 suicidal ideation-related hospitalizations by the end of 2011.
- ★ Military work stress (as a potential factor in suicide) replaced relationship problems in CY2010, which had previously led all stressors from CY2003-09.
- ★ In CY2010, average national unemployment for ages 18-24 and 25-34 was approximately 21% and 13%.
- ★ Research regarding the relationship between financial pressure and suicide has consistently found a strong correlation between economic conditions and suicide; suicides increase during financial crisis.
- ★ When the US unemployment rate was superimposed over the national suicide rates from CY1993-2009, it closely mirrored suicide rates across time.
- ★ Soldiers and Families will need additional assistance from their chain of command and program / service providers during transition from the military.

(8) Policy and Programs

As discussed in the *Red Book*, Army senior leaders have recognized that in order to tackle the tragic increase in suicides, policies and programs must address the larger issues of physical and behavioral health while increasing surveillance and detection of at-risk and high-risk behavior. Though the Army will never be able to predict whether a particular individual will commit suicide in the future, it can ensure that those at greatest risk receive adequate care and monitoring while bolstering its ability to identify and respond to risk indicators. Army policies and programs geared toward reducing suicides,

therefore, focus on the wider picture of promoting health, identifying risk factors and ensuring standardization in reporting.

In order to promote standardized reporting of suicide-related events, the Office of the Surgeon General issued Policy 09-032 (3 June 2009), *Standard Terminology for All Activities Involved in Investigating and Reporting Suicides, Suicide Attempts, Ideations, and Gestures*.¹⁷⁴ The policy codified the definitions of suicide attempts, suicidal ideation, and self-harm. These definitions were later incorporated into AR 600-63, *Army Health Promotion*, which states that a suicide attempt is “a self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die.” (Suicide attempts may or may not result in injury.) The policy defines suicidal ideation as “any self-reported thoughts of engaging in suicide-related behaviors (without an attempt).”¹⁷⁵

The Army is taking further policy measures to ensure that suicides are reported through appropriate channels in a consistent and standardized manner. The HP&RR Task Force has proposed revisions to AR 600-63 and DA PAM 600-24, to include changes to the *Commander’s 34 Line Report* (now known as the “Commander’s Suicide Event Report”), and that the *Report* be completed and submitted to the Deputy Chief of Staff, G-1, Army Suicide Prevention Program within 30 days of the suicide event (or equivocal death being investigated as a possible suicide), with an initial report submitted 5 days after the event.

The Army has also coordinated reporting with DoD through the DoDSER. The DoDSER is a collaborative effort by the National Center for Tele-health and Technology in coordination with all Service suicide programs. Its improved reporting accuracy from CY2008-10 (from 90-100% for all Armed Forces Medical Examiner (AFME) confirmed suicides) makes it a good source for data regarding Service-related suicides and suicide attempts.¹⁷⁶ AR 600-63 prescribes that MTFs designate a DoDSER Program Manager, who is responsible for collecting a DoDSER on every active duty suicide. The DoDSER will be completed for “all fatalities, hospitalizations, and evacuations of active duty Soldiers where the injury or injurious intent is self-directed.”¹⁷⁷ The DoDSER is required to be completed within 30 days of the suicide or self-injurious event or within 60 days of the event if it was later determined to be a suicide or self-injurious.

As reporting tools improve and data collection on suicide events continues to advance, the Army continues to invest significant resources in studying the underlying causes and risk factors associated with suicide, suicide attempts and other self-injurious behavior. According to congressional testimony by the Army G-1, LTG Thomas Bostick, “[t]he US Army Medical Research and Materiel Command (USAMRMC) is currently managing thirteen medical suicide prevention research projects; a total investment of \$79 million. These projects include the Walter Reed Army Institute of Research project on suicide ideation in a combat environment.”¹⁷⁸ One significant research investment, the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS), is highlighted in Chapter II, Section 4.c.(1).

Through the study of suicide and other self-injurious behavior, the Army has identified a variety of risk factors that indicate an increased propensity to commit or attempt suicide. One such risk factor is involvement in legal actions or investigations; there is a pronounced link between investigations or legal actions with high-risk behavior and suicides. As a result, the HP&RR Task Force has proposed policy changes to ensure that those involved in investigations receive enhanced monitoring by commanders in an effort to reduce occurrences of high-risk behavior, including suicides and suicide attempts. Changes include requiring “CID commanders and installation provost marshals (PM) / directors of emergency services (DES) in charge of law enforcement operations...to ensure that upon apprehension or initiation

of investigation of a Soldier, DoD Civilian, or contractor,...they will immediately notify the chain of command (Commander, Deputy Director or Civilian equivalent) within 4 hours and document via DA Form 3975 / Report of Investigation (ROI).” In addition, “Soldiers under law enforcement control will be released only to commanders or command sergeants major / first sergeants via DD Form 2708.” These changes ensure a “warm hand-off” between investigative authorities and leaders, which will improve leadership visibility over individuals who, statistically, will be more likely to engage in high-risk or self-injurious behavior.

Aside from reducing high-risk behavior, the Army continues to enhance policies regarding the care of the Force’s at-risk population. Through improvements to policy and programs, the Army has demonstrated a strong commitment to communication enhancement amongst the health triad, stigma reduction and increasing medical care access. For instance, OTSG Policy Memo *Release of Protected Health Information (PHI) to Unit Commanders* (30 June 2010) mandates that medical commanders provide unit commanders timely information to support the unit commander’s decision-making pertaining to health risks, medical fitness, and readiness of the Soldiers. In particular, it requires “medical commanders to proactively inform unit commanders within 24 hours of medical concerns relating to circumstances where the Soldier’s judgment or clarity of thought might be suspect by the clinician or to avert a serious and imminent threat to health or safety of a person, such as suicide, homicide or other violent action.”¹⁷⁹ These and other policy changes continue to underscore the Army’s total effort to improve surveillance, detection and response to self-injurious behavior and its associated risk factors.

One area that may require additional exploration is with respect to the psychological and performance effects of suicide on small unit readiness. The Army still does not know how the psychological effects of suicide affect those Soldiers left behind after the suicide, how suicides degrade unit performance, how it impacts the leadership, and the contagion effect towards impacting other high-risk behavior. Given the scope and magnitude of current research efforts including the comprehensive STARRS study, there is an opportunity to add this aspect of suicide as a research proposal.

LEARNING POINTS

- ★ Key definitions: (1) suicide attempt is a self-inflicted potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die (suicide attempts may or may not result in injury); (2) suicidal ideation is any self-reported thoughts of engaging in suicide-related behaviors (without an attempt).
- ★ Policy requires law enforcement to notify commanders within 4 hours of any Soldiers involved in serious crimes / incidents (e.g., apprehension / arrest or initiation of investigation).
- ★ Medical commanders will proactively inform unit commanders within 24 hours of medical concerns relating to circumstances where the Soldier’s judgment or clarity of thought might be suspect by the clinician or to avert a serious and imminent threat to health or safety of a person, such as suicide, homicide or other violent action.

d. Protected Health Information

Commanders have a duty to ensure the safety and well-being of their Soldiers while also making sure their units are trained and ready to conduct the missions assigned to them on behalf of the Nation. This dual responsibility has become particularly challenging in recent years given the demand on

Soldiers and Family members over the past decade of conflict. The level of readiness of a unit is measured in three key areas: manning, training and equipping. Personnel readiness (manning) reflects not only the number of individuals assigned, but more importantly, their level of physical and mental fitness. The task of measuring the level of fitness accurately is especially challenging considering the most prevalent wounds and injuries incurred on today's battlefields are invisible, primarily affecting an individual's behavioral health and cognitive function. Often the only way a commander may learn a Soldier has a problem or some level of diminished capability is: (1) to recognize symptoms or unusual behavior and then command-refer the Soldier for evaluation by a medical professional; (2) the Soldier informs the commander of a problem; or (3) the commander is in communication with the healthcare provider with respect to the Soldier's condition and method and status of treatment. The latter is the preferred option. However, patient privacy laws, most notably HIPAA, restrict the release of certain PHI.

PHI is "individually identifiable health information" that is created or received by a healthcare provider, health plan or employer; that relates to a person's past, present or future physical or mental health condition, the provision of healthcare to a person, or the past, present or future payment of healthcare; that identifies the person; and that is transmitted or maintained by electronic or any other form or medium.¹⁸⁰

The military health system must comply with the requirements of HIPAA, both as a healthcare provider through MTFs and as a "health plan" through TRICARE. Just as it does in the civilian healthcare system, DoD privacy regulations prohibit PHI from being used or disclosed "except for specifically permitted purposes" (e.g., releases to "Law Enforcement Officials")... "without the written authorization of the patient".¹⁸¹

That said, HIPAA does take into account the need for commanders to be able to effectively assess the physical and mental fitness of their subordinates. As such, the privacy rule of HIPAA provides standards for disclosure of PHI pertaining to Armed Forces members without their authorization.¹⁸² These standards include certain exemptions established to support the unique requirements of military operations. Under the "Military Command Authority" exception, commanders are permitted access to the information in their subordinates' medical and mental health records, without Soldier consent, under certain circumstances, including:¹⁸³

- To determine a Servicemember's fitness to perform any particular mission, assignment, order or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order or duty;
- To assess medical readiness and fitness for deployability (e.g., immunization status, temporary or permanent profile status, Medical Evaluation Board (MEB) / Physical Evaluation Board (PEB) related data, allergies, blood type, flight status);
- To initiate Line of Duty (LOD) determinations and to assist investigating officers in accordance with (IAW) AR 600-8-4 (Line of Duty Policy, Procedures and Investigations);
- To carry out Soldier Readiness Program and mobilization processing requirements IAW AR 600-8-101 (Personnel Processing In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing);
- To monitor the Army Weight Control Program;
- To provide initial and follow-up reports IAW AR 608-18 (The Army Family Advocacy Program).

Provisions also allow providers to provide commanders minimum necessary details about the condition or care of Soldiers in their command under certain circumstances, including:

- To avert a serious and imminent threat to health or safety of a person, such as suicide, homicide or other violent action;
- To warn commanders of medications that could impair the ability to perform assigned duties (e.g., drowsiness, altered alertness, slowed cognition);
- To warn commanders of conditions that can impair the Soldier's performance of duty;
- To recommend a command-referral to a substance abuse treatment program.

Requests for mental health and alcohol and substance abuse records are subject to additional laws and regulations. In cases that arise under the Uniform Code of Military Justice (UCMJ), a patient may refuse to disclose and prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist. However, the privilege does not apply in the case of administrative discharge actions involving mental disorders that interfere with a Servicemember's ability to serve in the military.

While providing commanders access to certain PHI is essential to ensuring that Soldiers are properly cared for and commanders are able to accurately assess the physical and mental fitness / readiness of their units, care must be taken to ensure Soldiers' right to privacy is not unnecessarily violated. If Soldiers feel there is a risk their private information will be improperly released, they may be unwilling to seek help, especially for behavioral health conditions, due to the stigma associated with these conditions and their treatment.

The Army is making progress in this area, particularly as it relates to behavioral health conditions. The Army has provided further clarification on existing policy (e.g., ALARACT 160 / 2010), while also encouraging commanders and providers to work more closely together. Doctors, for example, are now encouraged to notify a leader or commander if a high-risk Soldier misses a counseling session. The Army has also begun to require doctors to provide commanders a list of Soldiers' medical appointments without disclosing the reason or clinic. According to the hospital commander, "[t]he directive was put in place at Fort Stewart, Georgia and the no-show rate for behavioral health appointments has dropped from 22% to less than 10%."¹⁸⁴ Ultimately, the goal is to achieve an optimum balance that permits commanders access to the necessary information to enable them to better protect and promote the safety and well-being of the Soldiers under their command while at the same time maintaining Soldiers' right to privacy.



"Commanders play a critical role in the health and well-being of their Soldiers, and therefore require sufficient information to make informed decisions about fitness and duty limitations. I am directing several changes to policy and regulation in order to improve communication between patients and providers, commanders and patients, and commanders and providers."¹⁸⁵

– GEN Peter Chiarelli
Vice Chief of Staff, Army
30 June 2011

The Army has codified PHI policy through an OTSG Policy Memo, *Release of Protected Health Information (PHI) to Unit Commanders*, issued 30 June 2010 which is consistent with the DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, 17 April 2011. This memo closed one of the most critical gaps impeding communication and collaboration among the health triad. It prescribes in a direct fashion the following guidance:¹⁸⁶

- MTF commanders will provide timely and accurate information to support unit commanders' decision making pertaining to health risks, medical fitness and readiness of the Soldiers;
- MTF commanders will designate personnel (by roles) who will be authorized to release information to unit surgeons and / or unit command officials;
- MTF commanders will proactively inform the [unit] commander within 24 hours of medical concerns. Information will focus on circumstances where the Soldier's judgment or clarity of thought might be suspect by the clinician or to avert a serious and imminent threat to health or safety of a person, such as suicide, homicide or other violent action.

LEARNING POINTS

- ★ Measuring the level of Soldier fitness accurately is especially challenging considering the most prevalent wounds and injuries incurred on today's battlefields are non-visible, primarily affecting cognitive ability and behavioral health.
- ★ Under HIPAA's "Military Command Authority" exception, commanders are permitted access to the information in their subordinates' medical and mental health records, without Soldier consent under the circumstances previously highlighted.
- ★ These exemptions apply in the case of administrative discharge actions involving mental disorders that interfere with a Servicemember's ability to serve in the military.

e. Integrated Disability Evaluation System



"We need to do better in our transition handoffs from uniformed service to civilian status. The tragedy of Veterans' homelessness may arise months, more likely years, after servicemembers take off the uniform; but, it is still, for many, part of a prolonged transition as they deal with the "baggage" they carry from their time in uniform."

— *The Honorable Eric Shinseki
Secretary of Veterans Affairs*

Commanders are responsible for ensuring the fitness of their Soldiers. Soldiers assessed as unfit for continued military service because of physical disability must be separated or retired, with benefits provided for those eligible due to medical conditions incurred as a result of military service. Disability ratings, used to measure and categorize medical conditions that render Soldiers unfit for duty, are established in increments of 10% with disability ratings of 10%, 20%, 30%...100%. "The severity of the 'unfit' medical condition determines whether a Servicemember, who is eligible for disability benefits, receives disability retirement or is separated with severance pay."¹⁸⁷ Soldiers who receive a 30% or greater disability rating are eligible for disability retirement, while Soldiers who receive a disability rating of 20% or less may be eligible for severance pay.

One key issue is with respect to the timeliness of this process. Based on feedback from the field Army, the DoD Disability Evaluation System (DES) used to assess Soldiers for continued military service and the resulting communication to commanders take too much time. Often cited as too bureaucratic, the disability evaluation process, from medical assessments to board determinations on fitness for duty, leaves commanders and Soldiers in limbo. These processes often extend Soldier personnel (administrative or disciplinary) actions; decisions regarding Soldier employment, separation or

retirement status; and the number of Soldiers on active duty—all of which can result in an increase of unit at-risk populations.

The extension of Soldiers on active duty is further exacerbated by the fact that 26,000 Servicemembers—of which 18,000 are Army Soldiers—are undergoing disability evaluation at any given time.¹⁸⁸ Excluding WTU, DES accounts for an increase of 169% (6,948 to 18,671) in the Army at-risk population (based on health considerations) since January 2008. And the rate appears to be accelerating with a 50% (12,419 to 18,671) increase in the DES population, compounded by a 34% increase in processing time over the last year. This backlog in the system likely overlooks a larger population of Soldiers yet to be diagnosed or pending treatment programs prior to meeting eligibility for medical retirement or medical separation. As the Army streamlines other medical processes, Soldiers entering the disability evaluation process may be backed up at a key transition exit. In the final analysis, frustration in disability evaluation systems in the short-term may continue to divert medical resources from Soldiers projected to return to the readiness pool. Consequently, this has required the Army to man units at or above 110% to meet unit deployment requirements of 90% authorized strength.¹⁸⁹

DES transitioned to the Integrated Disability Evaluation System (IDES). “This system was developed to shorten the 540 days it took a Soldier from processing through the Army system and then processing through the VA system. In the new system...[n]ational data shows an average completion of 240-295 days vs. the legacy physical disability evaluation system.”¹⁹⁰ This transition is designed to improve integration between the DoD and VA disability evaluation systems, which currently differ in rating criteria as discussed below. The current DoD system is designed to determine the disposition of Soldiers who may have a disability that prevents or limits their ability to perform their duties based on their occupational function and rank. Unlike the VA system, it is performance based and addresses the question of whether Soldiers can—and to what degree—perform their prescribed military occupation with an intent to only compensate Soldier transition from military service to a civilian occupation. In essence the DoD disability rating only compensates for disabilities impacting continued military service based on the level of the Soldier’s duty fitness. On the other hand, the VA disability evaluation rating measures all service-connected disability “...regardless of whether it impedes a member’s military career. [The VA rating] is meant to compensate for potential losses in civilian earnings.”¹⁹¹ The challenge, however, is that “military retirement or severance pay due to disability is paid through the Defense Finance and Accounting System (DFAS) like normal DoD retired pay, but disability compensation for nonmedical retirees (the vast majority of service-connected disabilities) is paid through the VA.”¹⁹²

The new IDES is designed to reduce gaps in Army and VA determination for fitness and disability, which have created varying degrees of disability determination between Army and VA approved retirement and other disability benefits. “IDES features a single set of disability medical examinations appropriate for determining both fitness and disability and a single set of disability ratings provided by VA.”¹⁹³ It will be implemented through the MEB and PEB determination of fitness and, if determined unfit, a Soldier’s medical evaluation will be forwarded to the Veterans Benefit Administration for a final disability rating.

A recent policy revision to the narrative summary (NARSUM – summary of physical disability) is “expected to reduce MEB processing time, decrease appeal rates, and reduce the number of unnecessary return cases from the PEB.”¹⁹⁴ This policy also may help reduce the backlog and improve Soldier readiness. This is important in light of the fact that there are 14,982 AC Soldiers (18,530 all COMPOs) currently in the MEB / PEB process, and 15,113 Soldiers on active duty with a P3/4 profile who have been through MMRB / MEB process and retained.¹⁹⁵ As this population swells, the Army must

continue to review its fitness for duty standards to ensure that Soldiers are both employable and deployable in today's high OPTEMPO contingency-based environment.

Unfortunately IDES implementation may not be as efficient or effective as forecasted. Although streamlined, the new process still appears rather complex. "A typical Servicemember's case is handed off between the DoD and the VA nine times during the new integrative process."¹⁹⁶ The process generally starts about a year following a Soldier injury, during which a Soldier is undergoing rehabilitation and subsequent evaluation to determine fitness. If Soldiers have conditions that may not meet medical retention standards, they will begin the IDES process. Although the initial goal was to complete the retirement and disability determination in 295 days, estimates on process length as of August 2011 range between 373 and 400 days.^{197,198}

Time considerations aside, other issues noted in IDES include the fact that it still provides two ratings between DoD and VA, which is a source of Soldier confusion and frustration. Of the 5,328 Soldiers separated or retired through the IDES from November 2007 through 18 September 2011, 4,063 (76%) Soldiers received a lower disability rating from the Army for unfitting conditions than VA's rating for all service-connected conditions.¹⁹⁹ Consequently, many assessments, including the 2007 Dole-Shalala Commission, have recommended completely restructuring the disability evaluation system. As Philpott describes such a restructured system in his article, *Disability Evaluation Reform Seen Falling Short*, it would involve "...a single evaluation based upon one medical record, and over which Defense and VA officials have joined hands and made a decision: 'Here's the disability rating.'"²⁰⁰ Depending on how the change was structured, it could elevate the number of military members eligible as "disabled retirees," which could increase both retirement and medical costs.²⁰¹ This cost increase is a serious concern, as conservative estimates place the bill for future medical and disability benefits at \$600 billion to \$900 billion.²⁰² Both points, advocacy for a single system and subsequent retirement associated costs, demonstrate the complexity of this issue.

A premature closure to the larger IDES policy debate, however, both slights program implementation in its early stages and fails to anticipate key Service recommendations that could mitigate program shortcomings. The IDES process has only existed since 2007 as a pilot with national implementation across DoD and VA completed at the end of 2011. However, there are some key recommendations that may streamline the final system. Developing a single or interoperable IT system between DoD and VA would facilitate Soldier transition between departments. Also, the Army needs to increase the number of healthcare providers available to prepare the NARSUM. For example, the Army could increase its tele-health network to include other externally contracted health providers, increasing the provider pool in support of the IDES process while freeing up internal healthcare providers for traditional healthcare services.

VIGNETTE— LONG TERM LEGACY OF GWOT

On 26 September 2011 the VCSA attended the 2011 Defense forum in Washington, DC. During Q&A he heard disheartening stories from two veterans' spouses. One spouse was deeply concerned that her husband was on 70% disability and could not work. She also could not work because she had to stay home to provide him full-time care. Since they only receive \$1,300 each month they had to use their savings to pay the bills.

Another spouse shared her concerns. While awaiting his disability rating, her husband was prioritized below retirees at the military treatment facility and equally low at the VA for care. As a result of the latter, it remains difficult to make appointments for follow-up care of his injuries.

LEARNING POINTS

- ★ Soldiers assessed as unfit for continued military service because of physical disability must be separated or retired, with benefits provided for those eligible due to service-related medical conditions incurred as a result of military service.
- ★ There are 26,000 Servicemembers—of which 18,000 are Army Soldiers—who are undergoing disability evaluation at any given time.
- ★ There are 14,982 AC (18,530 all COMPOS) currently in the MEB / PEB process and 15,113 Soldiers on active duty with a P3/4 profile who have been through MMRB / MEB process and retained. As this population swells, the Army must continue to review its fitness for duty standards to ensure that Soldiers are both employable and deployable in today's high OPTEMPO contingency-based environment.

f. Reducing Stigma

Beyond the science, the biggest barrier to progress in the diagnosis and treatment of behavioral health conditions is the long-standing stigma associated with seeking and receiving treatment. Stigma is defined by American-Heritage dictionary as “a mark of shame or discredit.” Evidence of it exists throughout history. In colonial times, people with mental illness were described as “lunatics” and were largely cared for by families.²⁰³ The imperceptible nature of behavioral health injuries and conditions further contributes to the stigma. Because a person may appear perfectly fine, others are often less sympathetic in their response, as compared to the response provided those displaying readily apparent physical injuries, such as amputations, burns and wounds suffered in combat.

Researchers generally distinguish between two types of stigma: public stigma (the reaction of others to an individual or group) and self-stigma (the reaction of individuals to themselves [e.g., insecurity, embarrassment]). Both may contribute to a person’s reluctance to seek / accept treatment. The influence of stigma can be so significant, in fact, that many will choose to endure the effects of behavioral health conditions – even when they know they may be relieved or cured with treatment – rather than risk making others aware of what they fear will be perceived as a flaw or weakness. In many ways the stigma associated with behavioral health conditions is actually more disabling than the conditions themselves.

(1) Stigma in the Military

This stigma is especially pronounced in the military, where the pervasive culture is one of mental and physical toughness, “pushing through the pain.” Acknowledging a problem, particularly anything associated with an individual’s mental health, is frequently perceived as admitting weakness or failure. Stigma as defined in the *Red Book* (from a military perspective) is “the perception among Leaders and Soldiers that help-seeking behavior will either be detrimental to their career (e.g., prejudicial to promotion or selection to leadership positions) or that it will reduce their social status among their peers.”²⁰⁴ This concern precludes many of them from seeking or receiving treatment. In fact, studies indicate only about half get treatment.²⁰⁵ This is especially troubling given the prevalence of behavioral health issues and conditions, including post traumatic stress, alcohol abuse and depression, affecting our Force after a decade of war.

The key to eliminating stigma is engaged, involved leadership at every level. Leaders must take an active role in the care and well-being of their Soldiers. We have seen levels of involvement continue to improve Army-wide since the publication of the *Red Book* and, specifically, Chapter III, *The Lost Art of*

Leadership in Garrison. That said, sometimes the most well-intentioned efforts can be counterproductive or even harmful. For example, identifying Soldiers undergoing counseling or some other type of treatment by-name on a “high-risk roster”; affixing a red tag or ribbon to the helmets of Soldiers identified as heat casualties; and restricting a Soldier considered at-risk of harming himself to the unit’s common area all may increase stigma. While these actions are generally taken in an effort to protect these individuals through increased supervision, isolating them or singling them out in such a way is more likely to make things worse. Not only does it further contribute to individual stigma, it may very well deter others who, having witnessed a potentially embarrassing event, may be less willing to admit a problem or seek help for fear they will endure a similar experience.

The Army has made progress in recent years to reduce and eliminate the stigma associated with seeking and receiving help for behavioral health conditions. Some adjustments have been simple, yet impactful. For example, the Army moved the majority of behavioral health services from their proverbial ‘5th floor’ location to the general care areas located at military treatment facilities. The Army instituted pre-and post-deployment behavioral health screenings for every Soldier. It also embedded behavioral health providers in brigade combat teams in garrison and in primary care clinics. These and other measures were taken in an effort to reduce stigma by avoiding isolation of Soldiers who are help seeking. These steps also send a clear message that behavioral healthcare is part of a normal, routine maintenance cycle, no different than going in for a physical or for an exam due to a physical illness or injury.

VIGNETTE— THE COURAGE TO ASK FOR HELP²⁰⁶

A LTC recently credited his Family Readiness Group (FRG) and behavioral health programs for saving his life. During a Q&A session with ARNG and USAR leaders at the 2011 Association of the United States Army (AUSA) Convention, the LTC [an audience member] stated, “A year ago, my life was not so good. My marriage of 20 years was on the rocks, and I was about to get kicked out of the Army for self-destructive behavior.” While deployed to Afghanistan in 2007, the LTC was unable to join his commander, CSM and ten other Soldiers on a mission to Iraq. After coordinating their flight, he redeployed to CONUS. A former boss met him at the airport and informed him all 12 died after their helicopter was shot down near Baghdad. Wrestling with their deaths, the LTC was unable to cope in the subsequent three years and allowed it to impact his marriage and career. Fortunately for him, a concerned FRG member recognized his problems and ensured he received the behavioral healthcare he needed.

MG Raymond Carpenter, ARNG Acting Director, in thanking the LTC stated, “We absolutely have to have Soldiers who have had the experiences like you’ve had....we want them to seek help.” The LTC stated, “Sometimes you can’t just suck it up, you just need help.”

The Army also has expanded the number of front-line service providers across the Force, to include chaplains and chaplains’ assistants, behavioral health counselors, psychiatrists and psychologists, in an effort to provide our Soldiers with seamless and timely care, advice and referral services. Access to healthcare support services downrange has also improved dramatically, largely due to an increase in behavioral healthcare specialists assigned to units at battalion and brigade levels and at combat stress clinics. These much-needed improvements are good news; however, there is still a shortage of behavioral healthcare providers Army-wide. In fact, the supply of behavioral healthcare providers is inadequate Nation-wide. We must continue to look for ways to effectively address this shortage; recognizing that demand for these professionals is only going to increase in coming days.

It also should be noted that efforts to reduce stigma are not unique to the Army. In May of 2008, former Secretary of Defense Robert Gates announced the change made to Question 21 on the National Security Background Questionnaire (SF-86), eliminating the requirement for individuals to report if they have sought out counseling related to service in combat.²⁰⁷ The intent of the change was to alleviate the widespread concern among Soldiers that seeking help might jeopardize their security clearances and, in turn, their careers. In 2009, the Department of Defense, led by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), launched an anti-stigma campaign called the ‘Real Warriors Campaign,’ designed to promote resiliency, recovery and support for returning Servicemembers, veterans and their Families.²⁰⁸ This campaign’s DCoE Outreach Center provides access to psychological health information and resources 24 hours a day, seven days a week. Individuals can chat online with psychological health coaches or access additional support via email or by using the available toll-free number. Finally, in July 2011, President Obama reversed the long-standing policy that precluded families of Servicemembers who die by suicide while deployed to a combat zone from receiving presidential condolence letters. The intent, in part, was to help de-stigmatize the mental and behavioral health problems suffered as a result of combat.

Further improvement in this important area will require a multi-faceted approach. First, we must continue to educate people about these conditions. We must also be willing to talk about them, while encouraging others to do so as well, in order to make them less ‘taboo’ and more ordinary. We have undoubtedly benefited in recent years from the increasing number of high-ranking military officials, professional athletes and public figures who have come forward and shared their own experiences with depression, post traumatic stress, concussions and other conditions. Their efforts have further raised awareness while sending a clear message that it is okay to admit you need help. One of the most powerful examples of this is the series of public service announcements (PSA) by more than 30 Medal of Honor recipients titled “Medal of Honor: Speak Out! Save Lives.” These American heroes share their experiences and encourage today’s Servicemembers and veterans to seek help for behavioral health issues that are often a result of deployment and combat. The PSAs may be viewed at www.medalofhonorspeakout.org.

“When people understand that mental disorders are not the result of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate.”

– *“Mental Health: A Report of the Surgeon General”*
Department of Health and Human Services, 1999

While efforts to educate and inform individuals about these conditions are most important, to effectively eliminate stigma we must also continue to search for causes and effective treatments. There are numerous historical examples of science effectively validating widely disputed mental conditions. This further confirms the need for continued study of the science of the brain. In coming years, researchers, scientists and doctors will undoubtedly continue to improve methods of diagnosis and treatments for conditions such as post traumatic stress disorder and mild traumatic brain injury.

Untreated behavioral health problems will likely worsen over time, impacting Soldiers’ ability to perform their duties and also negatively affecting their personal and professional relationships. All the support services, resources and treatments will be ineffective as long as Soldiers are constrained by the associated stigma. Leaders and commanders must take an active role in educating their subordinates on these important issues, encouraging those who may need help to seek and accept treatment, while

being mindful of the potential impact or negative perceptions that may be derived by actions taken on behalf of these and other Soldiers.

LEARNING POINTS

- ➊ Stigma is defined in the Army as the perception among leaders and Soldiers that help-seeking behavior will either be detrimental to their career (e.g., prejudicial to promotion or selection to leadership positions) or that it will reduce their social status among their peers.
- ➋ A change made to Question 21 on the National Security Background Questionnaire (SF-86 or security clearance form) eliminates the requirement for individuals to report if they have sought counseling related to service in combat.
- ➌ All of the Army's healthcare services and resources will be ineffective as long as Soldiers suffer from stigma associated with help-seeking behavior. Commanders and leaders can take an active role in educating their subordinates on the importance of behavioral healthcare, while being mindful of the potential impact of negative leader / Soldier perceptions.

(2) Policy and Programs

DoD and the Army have continued to clearly state in policy that attitudes and behaviors which promote continued stigma against seeking behavioral healthcare are unacceptable and inconsistent with promoting the health of the Force and the other Services. DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, mandates all Services to "foster a culture of support in the provision of mental healthcare and voluntarily sought substance abuse education to military personnel in order to dispel the stigma of seeking mental healthcare and / or substance misuse education services."²⁰⁹

The Army promulgated implementing policy in AR 600-63, *Army Health Promotion*, with similar language to reduce structural barriers to behavioral healthcare and to reduce stigma traditionally associated with those services.²¹⁰ For instance, it requires the Army to establish "after-duty hours for behavioral health services; public awareness campaigns designed to educate the community on the availability of behavioral health services; and campaigns to de-stigmatize behavioral health services." It also mandates that, "[a]ll Army leaders will receive training on the current Army policy toward suicide prevention [including]... how to create an atmosphere within their commands that reduces stigma and encourages help-seeking behavior."

The Army also published DA PAM 600-24, *Health Promotion, Risk Reduction and Suicide Prevention* which explicitly states that "Soldiers may feel they cannot acknowledge the need for help without negatively impacting their careers. To combat the belief that seeking help is a sign of weakness, commanders are encouraged to reinforce the personal courage it takes to seek mental health help." In order to achieve this, it encourages commanders to "[eliminate] policies that discriminate against Soldiers who receive mental health counseling... [increase] behavioral health visibility and presence in Soldier areas...[and] normalize healthy help-seeking behavior through an aggressive strategic communications plan," among other actions. This policy also re-emphasizes paragraph 1-25(e) of AR 600-63, which prohibits Soldiers from belittling other Soldiers for seeking behavioral healthcare.²¹¹

While policy certainly reflects the changing nature of military culture with regard to stigma associated with seeking behavioral healthcare, there is still more work to be done. Non-visible injuries continue to carry a stigma, especially amongst young Soldiers. As discussed in Chapter II, section 2.b.,

Post Traumatic Stress (PTS) and Post Traumatic Stress Disorder (PTSD), stigma often can be associated with mental illness. For example, there are many who advocate changing the “D” from “Disorder” in PTSD to “I” for “Injury,” in an attempt to encourage help-seeking behavior. This example demonstrates that while the Army has taken significant policy measures to reduce the culture of stigma associated with seeking behavioral healthcare, change must occur within the broader perspective of national culture and policy.

LEARNING POINTS

- ★ DoD and the Army has continued to clearly state in policy that attitudes and behaviors which promote continued stigma against seeking behavioral healthcare are unacceptable and inconsistent with promoting the health of the Force and the other Services.
- ★ The Army has updated AR 600-63 and DA PAM 600-24 to reduce practices that promote stigma associated with seeking behavioral healthcare.

4. Army Response to an At-Risk Population

a. Wounded Warriors



“The Warrior Care and Transition Program (WCTP) is an enduring program in which the Army has invested significantly. While the size of the program may vary with time depending upon current US involvement in global peacekeeping, counterterrorism and other actions, the need for the WCTP will continue to exist.”

– GEN Peter Chiarelli
Vice Chief of Staff, Army

In 2007, the Army established WTUs at major military treatment facilities worldwide in order to provide support to those wounded, ill or injured Soldiers, (commonly referred to as Warriors in Transition [WTs]), requiring at least six months of rehabilitative care and complex medical management. Today, there are 29 WTUs at major Army installations and 9 CBWTUs located regionally around the US (figure II-27).²¹³ There were 9,794 Soldiers enrolled in WTUs and CBWTUs Army-wide as of October 2011.²¹⁴ Approximately 87% of this population has deployed and 10% is combat wounded.²¹⁵

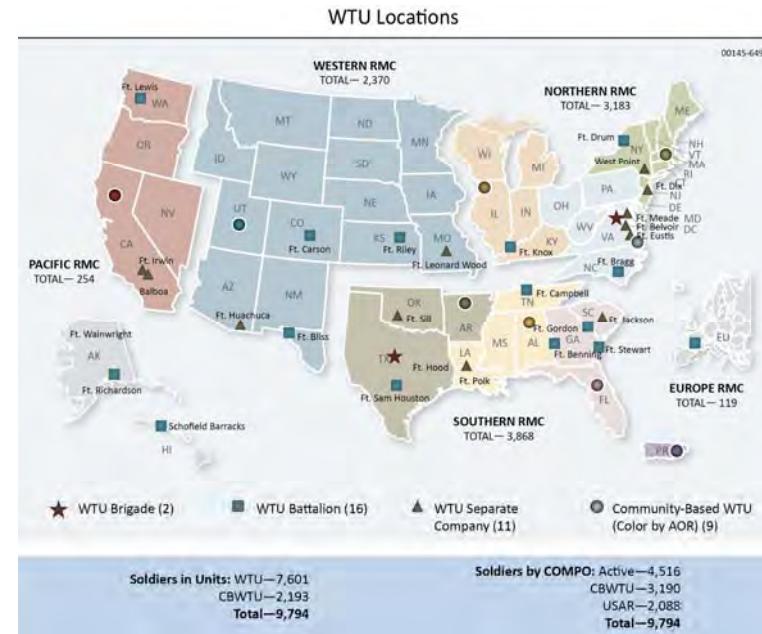


Figure II-27: WTU and CBWTU Locations²¹²

Prior to the creation of WTUs, most Active Component Soldiers requiring complex medical care remained assigned to their parent units or to a rear detachment. Some were assigned or attached to Medical Hold Companies overseen by the Army Medical Command. The establishment of WTUs created a more centralized system that was designed to achieve several goals: (1) synchronize and coordinate care and rehabilitation of WTs; (2) provide advocacy for Family members; and (3) allow commanders to fill positions encumbered by WTs and focus on unit readiness.

According to the Warrior Transition Command (WTC) website, WTUs closely resemble “line” units with a professional cadre and integrated processes designed to enhance unit cohesion and teamwork. The emphasis is to allow WTs to focus on healing, while Soldiers or wounded warriors prepare to transition back to the operational Army or to civilian status.”²¹⁶ At the WTUs, each Soldier works within a “Triad of Care,” which consist of a squad leader to help with Soldier issues; a nurse case manager, who is a registered nurse, to help with appointments, medication and healthcare consultations; and, a primary care manager, normally a physician, to manage the WTs’ care plans and all medical needs.

Key to the Army’s Warrior Care and Transition Program is the Comprehensive Transition Plan (CTP) (figure II-28). All WTs develop a CTP through the collaboration of a multidisciplinary team of physicians, case managers, specialty care providers, occupational therapists, social workers, behavioral health specialists and WTU leaders at all levels. This team helps the Soldier to develop individually-tailored goals that emphasize the transition back to duty or to civilian life across career, physical, emotional, social, spiritual and family domains.²¹⁷

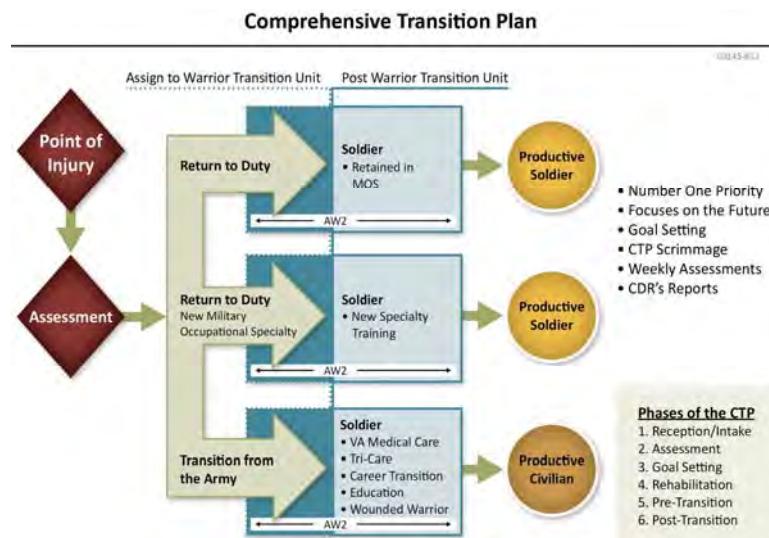


Figure II-28: WCTP Comprehensive Transition Plan

As illustrated in the chart in figure II-29, there were 9,825 Soldiers assigned to WTUs / CBWTUs (as of 13 September 2011). This population includes 4,581 (47%) AC Soldiers and 5,244 (53%) RC Soldiers; 7,596 (77%) are assigned or attached to WTUs and 2,229 (23%) managed by a CBWTU. The average length of stay in a WTU is 256 days; average length of stay in a CBWTU is 420 days. The chart graphically depicts lengths of stay for 9 cohorts (multiple colors) with the broadest portion of the color bands indicating months of entry into the program and the sweeping tails representing cohort reduction over time. The colors provide a nice illustration of both program capacity and care duration with each cohort consistently distributed between entry and departure. It also demonstrates the overlap among cohorts with what appears to be some members from among 4-5 cohorts enrolled at a single point in time. It clearly demonstrates the length of time Soldiers can remain in the program; a small portion of each cohort has remained upwards of three years.

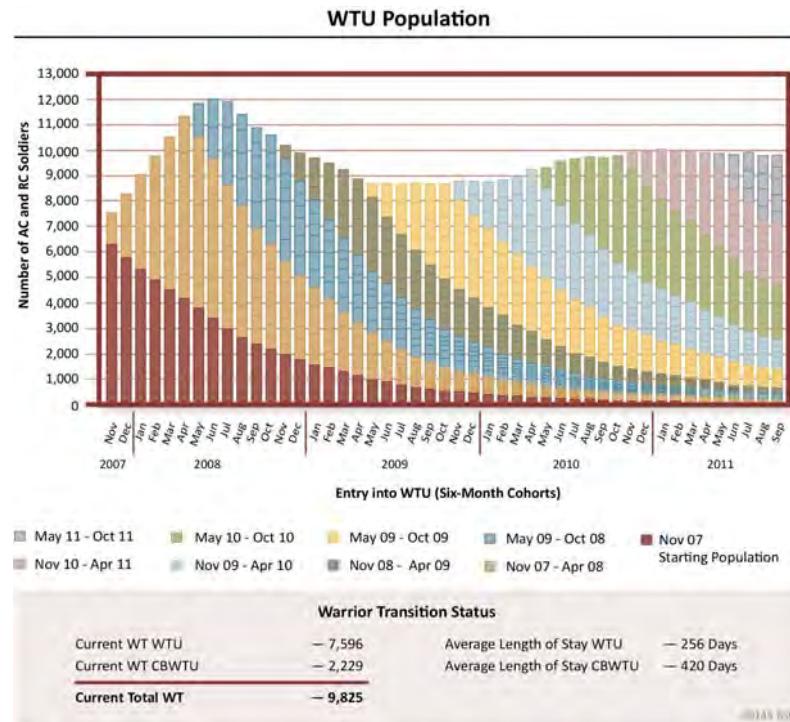


Figure II-29: WTU Population²¹⁸

While the vast majority of [WT] Soldiers (currently ~95%) are transitioned from the program in less than two years, there has been an increasing trend in length of stay for both WTU and CBWTU since November 2007 (figure II-30).²²¹ This is concerning given the fact that the chance that Soldiers will be returned to the Force decreases significantly the longer they remain in the WTU / CBWTU. Of those Soldiers assigned to the WTU for one year or less, approximately 44% are returned to the Force; of those assigned to the WTU for more than a year, but less than two years, approximately 8% are returned to the Force. Additionally, the decrease in throughput (number of Soldiers released each month) is mostly due to the severity of cases based on factors such as case mix, medical complexity, and recovery / rehabilitation requirements.

Ultimately, Soldiers enrolled in the WCTP leave the program in one of three ways: 1) Return to duty, retaining their military occupational specialty (MOS); 2) Return to duty with a new MOS; or 3) Transition from the Army. Since June 2007, WTUs / CBWTUs have returned approximately 19,000 Soldiers back to the Force (which roughly equates to five BCTs); while an additional ~18,000 WT Soldiers have separated from the Army.

From January 2007 to August 2011, 42,079 Soldiers (AC, ARNG, and USAR) assigned or attached to WTUs / CBWTUs have been released from the WT program with approximately 50% returned to the Force (Active and RC). Additionally, of the 42,079, 47% have been medically retired or separated, 3% released from the WT program for a variety of administrative and disciplinary reasons, and approximately 1% were deceased.²¹⁹ As illustrated at figure II-30, RC rates of return were significantly higher than those for the AC (~66% vs. 37%), which is consistent with the AC's rate of medical and administrative separations almost doubling the RC.

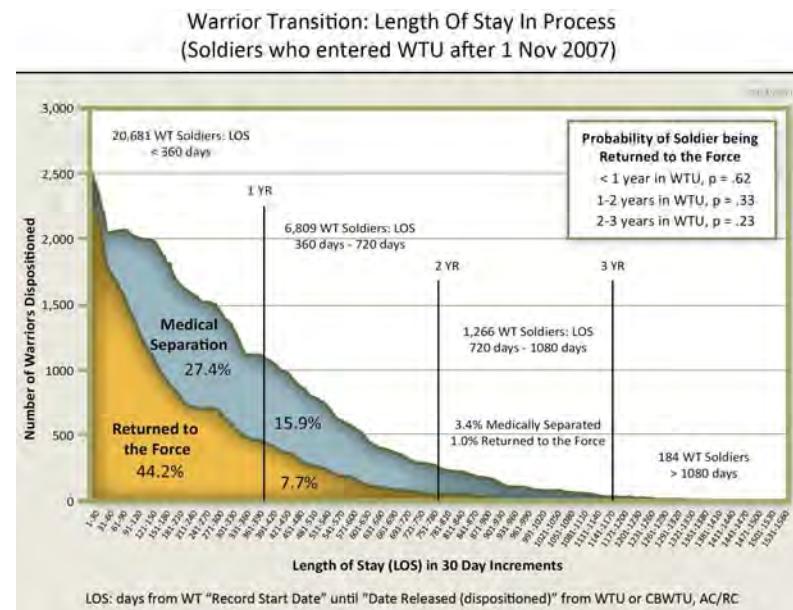


Figure II-30: Warrior Transition Length of Stay²²⁰

The difference in outcome (“Returned to the Force” vs. “Medical Separation”) for AC and RC Soldiers can be explained based on differences in “entry criteria” and demographics. AC Soldiers enter the WCTP due to complex medical conditions requiring six months or more of medical interventions and rehabilitation (FRAGO 3); the probability for initiating a MEB / PEB and being medically separated is much higher than that of an RC Soldier. RC Soldiers may enter a WTU due to the necessity for Medical Retention Processing Orders retaining the Soldier in an active duty status until the Soldier can be evaluated for a medical condition coincident to the Soldier’s AD status. The medical condition (disease and / or injury) may require treatment and either short-term or long-term rehabilitation. The probability that an RC Soldier would be released from active duty is much higher than their probability for medical separation, which reduces their medical separation rates below those for AC.²²²

Those who return to duty with a new MOS are enrolled in the Continuation on Active Duty (COAD) / Continuation on Active Reserve (COAR) program. This program is designed to allow Soldiers found medically unfit but who meet the criteria (IAW AR 635-40) and who want to continue to serve to do so in a different capacity.

Wounded, ill or injured Soldiers interested in applying for the COAD / COAR program must meet the following criteria: have 15 but less than 20 years of Active or RC service; or be in a critical or shortage MOS; or have a disability resulting from combat or an act of terrorism. There are currently 245 AC, 17 ARNG and 15 USAR Soldiers who are 100% disabled but are continuing their military service as a result of this program.²²³

The most severely wounded, ill and injured Soldiers are enrolled in the Army Wounded Warrior (AW2) Program. These Soldiers have or are expected to receive an Army disability rating of at least 30% in one or more specific categories or a combined rating of 50% or greater for conditions that are the result of combat or are combat-related.²²⁴ Historically, 12% of WTs are enrolled in AW2.²²⁵ An AW2 advocate provides personalized assistance with day-to-day issues that confront these Soldiers and Families, including benefits counseling, educational opportunities and financial and career counseling (figure II-31). Currently AW2 assists over 9,100 severely wounded Soldiers and their Families.²²⁶ It should be noted, the majority of the enrollees in AW2 are veterans (7,804), separated from military service, but still receiving advocacy through the AW2 program.

AW2 Essential Support Networks and Resources



Figure II-31: AW2 Program

Historically, 12% of WTs are enrolled in AW2.²²⁵ An AW2 advocate provides personalized assistance with day-to-day issues that confront these Soldiers and Families, including benefits counseling, educational opportunities and financial and career counseling (figure II-31). Currently AW2 assists over 9,100 severely wounded Soldiers and their Families.²²⁶ It should be noted, the majority of the enrollees in AW2 are veterans (7,804), separated from military service, but still receiving advocacy through the AW2 program.

The WTC is currently drafting a new Army Regulation on the WCTP that will further assist commanders, medical providers and members of the “Triad of Care” at WTUs / CBWTUs in their efforts to provide the best possible support to our WTs and their Family members. In the meantime, senior Leaders will need to determine the long-term construct of the WCTP and WTUs / CBWTUs, in particular, after the current conflicts in Iraq and Afghanistan end and all Soldiers return home. There is certain to be a requirement to provide continuing care to Soldiers and veterans for decades to come, especially given the prevalence of behavioral health conditions (e.g., major depression, post traumatic stress). The Department of Defense, Department of the Army and the other military services will need to work closely with the Department of Veterans Affairs to ensure eligible individuals have access to the necessary continuum of care and it is delivered as efficiently and effectively as possible for all involved.

LEARNING POINTS

- ★ While the vast majority of WT Soldiers (currently ~95%) are transitioned from the program in less than two years, there has been an increasing trend in length of stay for both WTU and CBWTU since November 2007 (figure II-30).
- ★ Since June 2007, WTUs / CBWTUs have returned approximately 19,000 Soldiers back to the Force (which roughly equates to five BCTs), while an additional ~18,000 WT Soldiers have separated from the Army.

b. Developing Resiliency in the Force



“The Army is leveraging the science of psychology in order to improve our force’s resilience. More specifically, we are moving beyond a “treatment-centric” approach to one that focuses on prevention and on the enhancement of the psychological strengths already present in our soldiers. Rooted in recent work in positive psychology, CSF is a “strengths-based” resiliency program that shows promise for our workforce and its support network so our soldiers can “be” better before deploying to combat so they will not have to “get” better after they return.”²²⁷

— GEN George Casey
36th Chief of Staff, Army

While it is important that Leaders and others recognize at-risk or high-risk behavior and intervene as early as possible, the health and discipline of the Force must not depend solely on reactive efforts. It is also necessary to help individuals develop coping skills and strengthen their resiliency so that they are better able to endure and manage the demands and stressors placed on them. This is particularly important for those serving in the military and in combat environments.

Resilience has been defined as “the process of successfully adapting to difficult or challenging life experiences. Resilient people overcome adversity, bounce back from setbacks, and can thrive under extreme, on-going pressure without acting in dysfunctional or harmful ways. The most resilient people recover from traumatic experiences stronger, better and wiser.”²²⁸ Recognizing the benefits of increased resiliency, the Army has actively pursued a long-term strategy aimed at helping Soldiers and Family members to improve their resilience and develop or enhance coping skills.

The centerpiece of these ongoing efforts is the CSF program. The Army established the Directorate of Comprehensive Soldier Fitness in 2008 with a goal of putting mind or mental fitness on par with physical fitness in terms of training, conditioning and leader involvement. The intent of CSF is to increase the baseline resilience of Soldiers prior to them experiencing difficult and stressful situations, particularly those common to combat environments. When faced with adversity or when experiencing a trauma, Soldiers will respond positively rather than negatively to the event or events.

The CSF program measures an individual's current level of resilience through methods of self-assessment. The primary mechanism is the Global Assessment Tool (GAT), a web-based, 105-question, confidential survey measuring a person's level of psychological health / fitness in four separate, yet interrelated dimensions –emotional, family, social and spiritual. All Soldiers are required to take the GAT annually. The survey measures such things as quality of friendships, strength of family relationships, level of optimism, depression and willingness to trust others.²²⁹ The reality is every person's level of resiliency is unique to him or her. Some people are naturally highly-resilient and can cope with tremendous amounts of stress and trauma with little adverse effect. Others have inherently low resilience and are troubled or distressed by seemingly simple events. The intent of the CSF program is to enable individuals to accurately identify their areas of strength, as well as areas for improvement related to resilience. Once an individual has this information, he or she may develop goals and a plan to reach those goals.

VIGNETTE— RESILIENCY

Roughly two months into his deployment, on his first day in Afghanistan's Arghandab Valley, a 1LT watched as two engineer vehicles exploded about 100 yards in front of him. An hour later, his platoon was in its first firefight. Two days later he was out with his platoon responding to a call from another unit when his 20-year-old forward observer, stepped on a makeshift bomb and was killed instantly. The 1LT was knocked down by the blast, but unhurt. Later that night, he was walking back to his platoon's position when he stepped on the trigger of a buried bomb. The explosion fractured his jaw, shattered his arm and blew off his legs. Since the event he has experienced no nightmares, no post traumatic stress disorder and none of the memory loss associated with traumatic brain injury.²³⁰ His mother told the Vice Chief of Staff of the Army her son, "has always been very resilient—even as a child."

Research clearly shows that resiliency can be learned and developed. The Battlemind program was an early effort by MEDCOM aimed at helping Soldiers, particularly those recently returned from combat environments, to improve their psychological health. (Battlemind techniques have subsequently been incorporated into CSF.) According to a study published in the *Journal of Consulting and Clinical Psychology* in October 2009, individuals with high levels of combat exposure who received Battlemind debriefing reported fewer PTS and depression symptoms, fewer sleep problems and lower levels of stigma.²³¹ Likewise, a study of military veterans of Operations Enduring and Iraqi Freedom found that "higher levels of resilience served as a protective factor for individuals with high combat exposure," also associated with "decreased suicidality, reduced alcohol problems, lower depressive symptom severity, and fewer current health complaints and lifetime and past-year medical problems."²³² While still in the early stages, analyses conducted to date using GAT data has shown measurable improvements in resiliency in sample populations of Soldiers surveyed.

To aid individuals in increasing their levels of resilience, the CSF program provides Comprehensive Resilience Modules (CRMs)—online, evidence-based training modules that focus on specific skills in each of the five dimensions of health. A Soldier may also participate in classes led by unit Master Resilience Trainers (MRTs). There are currently over [7,000] MRTs trained and assigned to units at the brigade, battalion and, in some cases, company levels.²³³ The goal is to help individuals target those areas where improvements may be made in order to increase their overall resilience levels, rather than simply respond to crises, as shown in figure II-32. Internal CSF longitudinal and cross-sectional studies have shown significant improvements in resiliency and psychological health for units with MRTs as compared to a control group without MRTs, especially for younger Soldiers (18-24 years old).²³⁴ Additionally, resiliency training is being incorporated in both officer and non-commissioned officer PME programs and in schoolhouses Army-wide. The message conveyed to Soldiers is an important one: improving resiliency is a lifelong endeavor.

“Physical fitness is not achieved by a single visit to the gym, and psychological strength is not achieved by a single class or lecture. It is achieved by learning, practicing what you have learned, seeing the results and then learning more.”

— *Comprehensive Soldier Fitness brief*

Improving Soldiers' coping skills is not only important to ensuring their short- and long-term health; it also represents a readiness issue. As indicated in Figure II-33, Soldiers with lower emotional fitness scores (based on GAT surveys) make, on average, more visits to primary care providers during deployment than those with higher emotional fitness scores. In fact, those Soldiers reporting the lowest emotional fitness scores (<2) made nearly twice as many visits to primary care providers as compared to individuals with the highest emotional fitness scores (4-5). While this represents double the cost at the primary care level, the real bill comes as Soldiers are referred on to subsequent levels of care (e.g., behavioral health specialists, prescription medications). And, this expense is not unique to the military. According to the SAMHSA report *Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004-2014*, “[b]y 2014, expenditures on mental health (MH) and substance abuse (SA) treatment [in the US] are projected to reach \$239 billion, up from \$42 billion in 1986 and \$121 billion in 2003.”²³⁵

Meanwhile, the cost of behavioral health conditions is not restricted to financial expenditures. It also reflects loss of

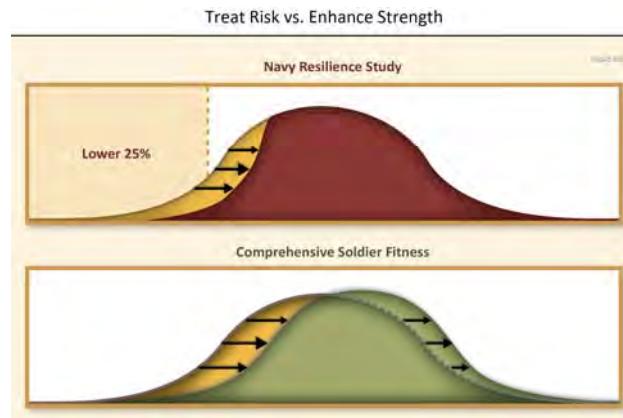


Figure II-32: Treat Risk vs. Enhance Strength

Internal CSF longitudinal and cross-sectional studies have shown significant improvements in resiliency and psychological health for units with MRTs as compared to a control group without MRTs, especially for younger Soldiers (18-24 years old).²³⁴

Additionally, resiliency training is being incorporated in both officer and non-commissioned officer PME programs and in schoolhouses Army-wide. The message conveyed to Soldiers is an important one: improving resiliency is a lifelong endeavor.

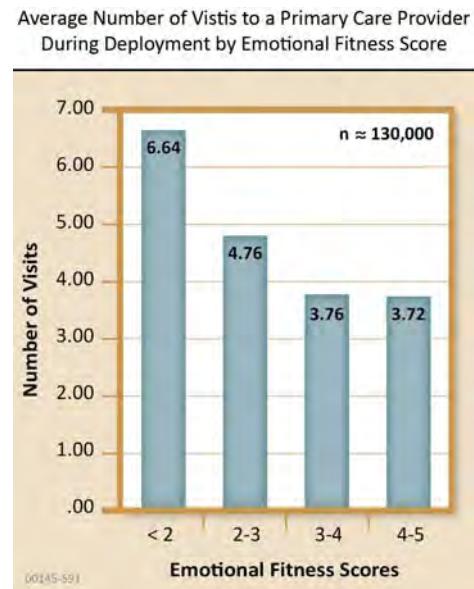


Figure II-33: Visits to a Primary Care provider by Emotion Fitness Score

time and productivity, diminished quality of life, strain on personal and professional relationships and other impacts. The goal of the Army's training program is to help individuals to improve their resiliency and coping skills, thereby reducing the overall cost burden on them, their Families and on the organization.

While the primary aim of the CSF program is "to assist the Army in developing resilient Soldiers," by "providing [those Soldiers already serving in our ranks] with skills needed to take care of themselves, their families and their peers," the analysis of survey data may also prove useful in the future in terms of identifying candidates and recruits with either high or low levels of resilience.²³⁶ The reality is the military may not be a good choice for a young man or woman with significant behavioral health problems or low levels of emotional fitness. Analysis of GAT survey data has shown that attrition rates for Soldiers with low GAT scores are much higher as compared to Soldiers with average or above average GAT scores. In fact, the rate of attrition for Soldiers in the bottom 10% (based on GAT survey data) is three times higher than the other 90% of the population.²³⁷ Soldiers in the bottom 10% also account for a significant portion of the population involved in illicit drug use and violent crimes. Caring for and properly disciplining these Soldiers consumes a significant portion of leaders' time. These Soldiers also end up costing the Army a great deal of money. Last year, for example, approximately 10% of recruits (~92K total recruits) dropped out during basic training.²³⁸ Each recruit costs the Army roughly \$77K.²³⁹ This represents a total loss of nearly \$710 million. And, the high rate of attrition also holds true during the Soldiers' (in the bottom 10%) first duty assignments and initial deployments.

Part of the challenge of improving an individual's resiliency is measuring success. Unlike physical fitness levels which may be measured by a physical aptitude test, psychological health or fitness, and particularly improvements made to the same, are oftentimes difficult to assess. Certainly as more funding is applied and time is invested in CSF and other resiliency programs, it will become increasingly important to find ways to verify their effectiveness. Right now the only measure is the GAT. However, those survey results are confidential. Commanders, for example, cannot acquire or ask their Soldiers to provide GAT scores. This is a point of contention for many Commanders who believe they should be allowed access to this information in order to identify and assist those high-risk Soldiers under their command.

As stated on the CSF program's website and on the outer instruction page of the GAT, "The GAT was never intended to be used as a selection tool."²⁴⁰ That said, there would be an obvious benefit if some similar type of evaluation tool existed that would enable commanders, recruiters and others to identify those Soldiers with behavioral health problems or low levels of mental fitness. As the Army, already under the tremendous stress and strain of a decade or more of conflict, prepares to get smaller, it will become increasingly important that leaders select the right people to join the Army's ranks. A report published in November 2006 by the US Army Research Institute for the Behavioral and Social Sciences states:

Due to the predictive power of education level, it is typically used for selecting personnel for service in volunteer-based systems. However, since most inductees in the US, for example, already have a high school diploma, education level is no longer a good indicator of attrition (Moore, 2002).²⁴¹

A person's psychological health, on the other hand, may prove to be a much more accurate and useful measure. As further research is conducted in this area, the Army may consider applying these and other findings to improve the effectiveness of US Army Recruiting Command's (USAREC's) screening and evaluation processes.

In the meantime, leaders must make mental and behavioral health fitness a command priority on par with physical fitness. The Army's resiliency training program can only be effective if it is employed properly and holistically. This includes picking the right individuals to participate in the Master Resiliency Training program and serve as unit MRTs. Bottom line: we must be proactive in our efforts to increase the resiliency of our Force, a Force that has been at war for over a decade and is stressed and strained—physically and mentally. Leaders' and Soldiers' ability to cope and to manage the difficult challenges that lie ahead as we transition from a war-time to a peace-time Army will ultimately determine our readiness and, in turn, our ability to meet the demands of the Nation in the future.

LEARNING POINTS

- ★ Recognizing the benefits of increased resiliency, the Army, in recent years, has actively pursued a long-term strategy aimed at helping Soldiers and Family members to improve their resilience and develop or enhance coping skills.
- ★ The intent of CSF is to increase the baseline resilience of Soldiers prior to them experiencing difficult and stressful situations, particularly those common to combat environments.
- ★ Army policy continues to promote mental and behavioral health fitness as a command priority on par with physical fitness.

c. HP/RR/SP Research Programs



“I wholeheartedly believe, twenty years from now, when we look back on this war the greatest advances in military medicine will have been made in the area of brain science.”

— GEN Peter Chiarelli
Vice Chief of Staff, Army

One of the most significant challenges facing the Army in the years ahead with respect to the health of the Force is the nascent nature of brain science. While much has been learned by members of the medical and scientific communities in recent years, there is still a great deal we do not yet know and will need to discover. The prevalence of behavioral health injuries demands this study remain a priority. And, not simply for the sake of wounded, ill and injured Servicemembers. The reality is injuries and illnesses affecting the brain are common across our society. As discussed earlier in the chapter, there is a growing awareness and greater appreciation for the seriousness of sports-related concussions, both among professional and school-aged athletes. Meanwhile, millions of Americans suffer from Alzheimer's disease or other dementia. And, the numbers are expected to grow significantly—even double over the next few decades—as the proportion of the US population that is over age 65 continues to increase.²⁴² Fortunately, there is a multitude of professionals, including doctors, researchers, scientists and others working tirelessly in this important area. They have made remarkable progress in recent years and are continuing to pave the way in what is largely “uncharted territory.” As noted in the *Red Book*, there is a tremendous amount of Health Promotion / Risk Reduction / Suicide Prevention (HP/RR/SP) -related research currently being conducted by numerous entities and organizations, both internal and external to the Army. Below is a brief summary of two, in particular, that continue to show great promise.

(1) Army STARRS

The Army STARRS (Study to Assess Risk and Resilience in Servicemembers) represents a partnership between the Army and NIMH. The collaboration also includes investigators from the Uniformed Services University of the Health Sciences, Harvard Medical School, University of Michigan, and University of California, San Diego. The 5-year, \$50 million study began in the fall of 2008. It represents the “largest study of mental health risk and resilience ever conducted among military personnel.”²⁴³ It is frequently compared to the Framingham Heart Study begun in 1948 to “identify the common factors or characteristics that contribute to cardiovascular disease, the leading cause of death and serious illness in the US.”²⁴⁴

Army STARRS consists of four separate study components – the Historical Data Study, examining more than one billion Army data records; the New Soldier Study, a census of new recruits, to include longitudinal follow-up in some cases; the All Army Study, a survey of active duty Soldiers, including mobilized Reserve and National Guard Soldiers located in the US, Afghanistan and other installations worldwide; and, the Soldier Health Outcomes Study, comparing Soldiers who committed suicide or attempted to commit suicide with Soldiers who had similar characteristics or experiences, but did not attempt suicide.²⁴⁵ The goal of the study is to identify potentially relevant risk factors, as well as “protective” factors. It is without question a remarkably complex study topic. As noted on the NIMH website:

Suicide is a very rare and complicated event. In fact, on average, fewer than 20 people out of every 100,000 commit suicide. In addition, there are few, if any, things that are common to *all* suicides. For example, although some risk factors such as clinical depression or failed relationships often precede suicide, most soldiers who experience these things never try to take their own lives.

For this reason the efforts of the Army STARRS team are critically important. The reach and magnitude of this study will enable researchers to examine the issues in-depth and draw valid scientific conclusions. And, most importantly, what is learned will have implications not only with respect to suicide, but a wide range of behavioral health-related issues, including depression, anxiety, traumatic brain injury and post traumatic stress. Likewise, what is discovered will not only lead to a reduction in the number of suicides and other behavioral health issues within the military ranks, it will ultimately benefit society as a whole.

(2) National Intrepid Center of Excellence

The National Intrepid Center of Excellence (NICoE), located adjacent to the Walter Reed National Military Medical Center in Bethesda, Maryland, is a state-of-the-art facility “dedicated to providing care to service members and families dealing with traumatic brain injury (TBI), [post traumatic stress] and [other] psychological health conditions.”²⁴⁶ The *Intrepid Fallen Heroes Fund*, the same fund that built the Center for the Intrepid, the world-class state-of-the-art physical rehabilitation center at Brooke Army Medical Center in San Antonio, Texas, led the fundraising effort for the NICoE, securing \$65 million in private donations nationwide.

The purpose of the NICoE is to advance traumatic brain injury and psychological health treatment, research and education. NICoE treats the most complex cases of TBI, PTS and other psychological health conditions. The ultimate goal is “to help those eligible service members return to active duty.”²⁴⁷ To this end, the center employs the very best doctors and experts in the field; it provides the most

advanced services and treatments; it also features cutting-edge technology, including some of the most advanced imaging technologies in the world. Commanders and healthcare providers may refer Servicemembers to the center. Selected patients spend three to four weeks there, along with their Families, working closely with an expert team of interdisciplinary specialists responsible for their care.

VIGNETTE— NATIONAL INTREPID CENTER OF EXCELLENCE²⁴⁸

The Vice Chief of Staff of the Army, GEN Chiarelli, participated in a Congressional Mental Health Caucus Briefing panel discussion in May 2011. One of the other panelists, an Army spouse, shared her family's story. Her husband was an Army Staff Sergeant, with two combat tours to Iraq. During his last deployment he was involved in two separate incidents where the vehicle he was riding in was hit by an IED. When he returned home, his wife described him as "a totally different person." He was withdrawn, depressed, often agitated and hostile. He wasn't able to work or even leave the house. The couple's two young children could not understand "why daddy looked the same, but acted so differently." His wife, in tears, said she "could not leave him alone even just to go to the store to pick up a gallon of milk for fear he would harm himself." They had seen several doctors, but none had been able to help them.

The VCSA immediately referred the Staff Sergeant and his wife to the NICoE. They underwent four weeks of treatment and have seen significant improvements in his condition.

In addition to providing clinical care, the mission of the center also includes "expanding the body of research about TBI and psychological disorders and sharing it with the broader medical community."²⁴⁹ Ultimately, the goal is to learn more about TBI, PTS and other conditions from studying and treating the most complex cases; then actively share those lessons learned broadly across the medical and healthcare communities worldwide. The Center of Excellence model is quickly gaining support as evidence of its effectiveness grows with each patient success story.

LEARNING POINTS

- ★ What is learned will have implications not only with respect to suicide, but a wide range of behavioral health-related issues, including depression, anxiety, traumatic brain injury and post traumatic stress.
- ★ Ultimately, the National Intrepid Center of Excellence's goal is to learn more about TBI, PTS and other conditions from studying and treating the most complex cases; then actively share those lessons learned broadly across the medical and healthcare communities worldwide.



==

This page has been left blank intentionally.

III – Discipline of the Force: The High-Risk Population [Outcomes of a High-Risk Population]

1. Introduction

Chapter II provided an overview of the Army's "at-risk" population, a population, whether suffering from injuries or behavioral health issues, is help-seeking with individual intent to return to health and readiness. This chapter examines the more serious population of high-risk Soldiers who may or may not be suffering from injuries or behavioral health issues, but are not help-seeking and whose behavior unequivocally "...places the individual or others in danger or harm's way."²⁵⁰ Further, this chapter illustrates the complexity of reducing this high-risk population within the Army, examines types of crime and high-risk behavior that result from this population, and details the Army's corresponding surveillance, detection and response efforts to identify and reduce their effects. As such, it begins with the complexity of high-risk behavior; describes the current status of crime and other high-risk related incidents; examines gaps in Army surveillance, detection and response; discusses policy and program implementation; and finally, provides learning points to increase discipline in the Force.

Overall, the Army is moving in the right direction, but as demonstrated in the remainder of this section, there is still more work to do. While HQDA has recently made sweeping changes to policy and programs to improve discipline in the Army, promulgation and execution always take some time to inculcate. Additionally, revising, updating or drafting policy that will affect more than 700,000 Soldiers must be thoroughly vetted to prevent unintended consequences and reduce administrative burdens. In FY2011 alone, for example, HQDA published policy to reduce gaps in law enforcement to include: prohibited use and possession of certain synthetic drugs (February 2010); increased specific manning levels for drug suppression teams on its larger installations (February 2011); required all drug investigations be conducted by CID (February 2011); and required CID to notify commanders of the initiation of all serious investigations to mitigate potential self-harm (October 2011). While these changes will assist commanders with surveillance, detection and identification of potential high-risk Soldiers, some gaps remain.

For example, while the Army has reduced the number of (if not almost eliminated) felony conduct accession waivers to prevent that particular sect of high-risk individuals from entering the Force, it still must draft policy to track separation "initiation" of Soldiers who commit similar crimes and formulate policy to identify Soldiers (e.g., centrally flag) who commit multiple felony offenses.⁷ Additionally, the Army has published policy limiting prescription medication use to six months from issuance but still must promulgate implementing guidance to inform commanders on the administrative and disciplinary actions that should be taken for its misuse. Finalizing these and other policies are critical so that commanders have visibility over the Soldiers in their units and understand the appropriate and expected actions that they must take against the Soldiers who violate these policies.

⁷ Felony and misdemeanor offenses are defined by Army policy (e.g., AR 195-2, AR 190-30, AR 27-10, AR 380-67): felony is defined as any criminal offense punishable by confinement for a term of more than one year; misdemeanor is defined as any criminal offense punishable by confinement for a term not exceeding one year. For the purpose of this study, Soldiers referenced in conjunction with crime statistics were the subjects of founded felony or misdemeanor offenses. It is unknown whether commanders or civilian courts adjudicated these offenses. The determination that a founded offense exists is made by law enforcement personnel (supported by legal opine) based on probable cause on review of the totality of the circumstances. It is not dependent upon judicial decision.

Army leaders, commanders and program managers must continue to develop and implement policy and programs to ensure continued progress. Essentially, the right policy and programs are either available or in draft that could close the remaining gaps in administrative and disciplinary processes and, ultimately, significantly reduce crime and high-risk behavior across the Army. It will require immediate action at HQDA to publish remaining policy and focused effort at the field level to achieve consistent implementation. Time is of the essence. As discussed in Chapter I, the Army is approaching the strategic reset and has an opportunity to select and retain professional Soldiers to fill its ranks ahead of Force reductions and other associated constraints. In other words, the Army has an opportunity to de-select and separate those Soldiers who do not meet the professional standards of conduct required of an all-volunteer Force.

The message is clear; the clock is ticking for Soldiers who willingly commit crime and exhibit high-risk behavior. Figure III-1 provides a metaphor that illustrates the impact of these Soldiers on the Force. Somewhere in the Army, at any given time, someone is committing an act that violates Army policy—policy designed to protect the health and welfare of its Soldiers and Families and the strength of the Army. High-risk behavior has a tangible impact on the readiness of

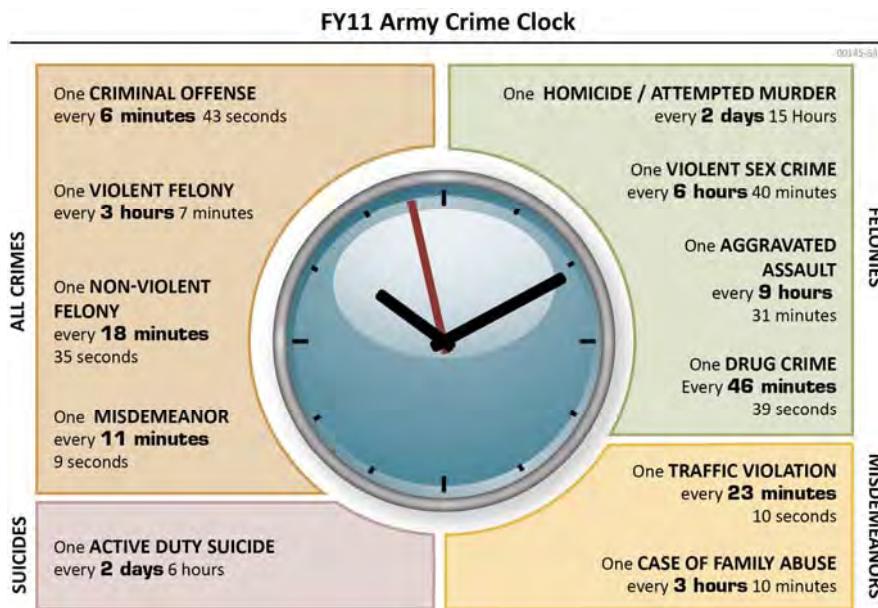


Figure III-1: Army Crime Clock

the Force. In FY2011 alone, criminal activity and high-risk behavior may have reduced the readiness or deployability (for some period of time)—of 18,022 Soldiers (2.6% of the Army). This number does not include serious misdemeanors such as AWOL and DUI which obviously impact any measure of readiness, particularly when the latter is associated with healthcare or rehabilitation. Consequently, readiness as measured by offenders and victims of all serious crimes would impact approximately twice the number of Soldiers in FY2011.

LEARNING POINTS

- ❖ The Army is approaching the strategic reset and has an opportunity to select and retain professional Soldiers to fill its ranks ahead of the Force reduction and other imposed constraints. Stated another way, the Army has an opportunity to de-select and separate those Soldiers who do not meet the professional standards of conduct required of an all-volunteer Force.
- ❖ In FY2011 alone, criminal activity and high-risk behavior may have reduced the readiness or deployability (for some period of time)—of 18,022 Soldiers (2.6% of the Army).

2. Complexity of High-Risk Behavior

High-risk behavior often includes some level of criminality; in this sense, it is a violation of law or Army policy. Violations of law and policy are defined under the Uniform Code of Military Justice (UCMJ), which also assimilates violations of all punitive policy under Article 92 as Failure to Obey Order or Regulation. However, there is often a blurred line of appropriate response when adjudicating Soldiers who engage in high-risk behaviors. This complexity is recognized in the Army's Risk Reduction Program (AR 600-85) which lists 21 risk factors that commanders and program managers need to monitor. Of these, 11 are criminal in nature (e.g., drug and alcohol offenses, AWOLs, traffic violations, family abuse, crimes against persons, etc.), 5 are related to safety, disciplinary and administrative actions (e.g., courts-martial, non-judicial punishment, administrative separations, etc.), and 5 are related to personal conduct (accidents, injuries, financial problems, etc).²⁵¹

Whether criminal or non-criminal in nature, high-risk behavior can result in increasingly more severe outcomes. This is true when excessive drinking becomes drunk and disorderly conduct, when failure to wear a motorcycle helmet results in a severe head injury or when non-compliance of prescription medication ends in a drug overdose. These examples demonstrate how at-risk behavior may escalate into high-risk behavior which can result in adverse health and disciplinary consequences. These are interdependent problems that must be addressed via interdependent solutions. When Army surveillance and detection systems converge in the identification of both at-risk and high-risk behavior, these behaviors must be addressed appropriately through both referrals to program enrollment and treatment (health), and by leader disciplinary and administrative actions (discipline).

VIGNETTE—HISTORY OF DRUG USE

A 25-year-old SGT developed a pattern of illicit drug use and alcohol problems during his five-year career. He tested positive for marijuana; no action was taken by his commander. He was apprehended three years later for the use and distribution of marijuana. There is no record of administrative or disciplinary action taken. Two years later, he was apprehended for driving under the influence and fleeing the scene of an accident. He attempted suicide that evening by ingesting alcohol and supplements. Behavioral health specialists indicated that he was not a threat to himself and subsequently released him to his unit. The SGT went AWOL a month later and hanged himself the following month. Toxicology results reflected THC (marijuana) in his system at the time of his death.

Although this chapter covers statistical analysis of both criminal and non-criminal high-risk behavior, it generally focuses on the former based on two factors: first, the majority of high-risk behavior is criminal in nature and second, the majority of Army data on these behaviors reside in criminal, disciplinary and administrative databases. While the analyses of high-risk behavior draws upon all available criminal and risk program databases it recognizes that there is a significant amount of high-risk behavior that is routinely handled at the unit level through AR 15-6 investigations, commander inquiries, administrative action and counseling for which there are no centralized data sources (and is therefore not considered).

a. Shifting Perceptions of Criminality

High-risk behavior is too often separated from its criminal aspect based on a subtle delineation of describing the criminal act as an unacceptable behavior such as AWOL, disobeying a lawful order,

violation of a general order, disrespect, failure to repair, fraternization, etc. Another aspect of this delineation is based on the method by which the criminal act is adjudicated. Administrative actions, for instance, can negate the linkage between the behavior and its criminality such as when a Soldier is separated for misconduct rather than (prosecuted at a court-martial) for a criminal act.

Even policy can blur the clear distinction between criminality and misconduct. As recent as February 2011, the Army published AR 601-210, *Active and Reserve Components Enlistment Program*, which provides a good example of decoupling of the criminality from behavior that may result in shifting perceptions toward acceptability. This new publication changes:

- (1) All references of serious criminal misconduct to major misconduct (throughout).
- (2) All references of misdemeanor offenses to misconduct offenses (throughout).
- (3) All references of moral qualification or waiver to conduct qualification or waiver (throughout).

Recognizing the potential criminality in these behaviors is essential because the role of the commander in correcting these behaviors is that of both investigator and judge. It is a critically important role and one that is unique to the military under the UCMJ. The utilization of these subtle euphemisms may dampen the seriousness of the offense and the somberness of the commander's role and responsibility to apply justice. For instance, it may be easier to justify retention of a Soldier for major misconduct than if the same misconduct was appropriately labeled as a felony offense. To be clear, a Soldier convicted for illicit use of marijuana (which may be characterized as a major offense) nevertheless has committed the equivalent of a felony under the UCMJ. Again, if that Soldier commits a second offense, that Soldier has not committed two discrete acts of major misconduct but rather multiple felonies. Regardless of how we label high-risk behaviors, these are often criminal offenses that erode discipline across the Force. Additionally, by waiving felony crimes, policy is at least in part communicating a level of tolerance for these types of crimes.



"In some cases there are discipline problems that we have not paid as much attention to as we should...[i]f you allow that to go unnoticed it becomes cancerous."

– LTG Mark Hertling
CG, US Army Europe

Although the example above cites language changes to accession policy, data analysis demonstrates that there is an uneven application in adjudicating some high-risk behaviors throughout the Force. Adjudication of marijuana offenses from FY2006-11 presents a case in point. Of a random sample of 227 cases of marijuana use (first time offenders) referred to commanders by law enforcement, DA Form 4833 (*Commander's Report of Disciplinary or Administrative Action*) data shows that: 81 Soldiers received Article 15s (at varying levels) with 18 separated from the Army; 63 received administrative actions (e.g., written admonishment); 47 were returned with no action taken by the commander and 36 had no record of adjudication (DA Form 4833 was never returned). Perhaps more concerning: of the 47 cases returned with no action taken (i.e., administrative or disciplinary), 19 Soldiers went on to offend again.

VIGNETTE— MULTIPLE DRUG OFFENDER CONTINUES TO SERVE

A 23-year-old Soldier tested positive for illicit drugs on multiple occasions dating back to October 2005 when he tested positive for cocaine. On 29 March 2008 he tested positive for Ecstasy, self-enrolled in the Army Substance Abuse Program (ASAP) and tested positive again for Ecstasy on 31 March 2008. He deployed in support of OIF from November 2008 to October 2009. In April 2010, he tested positive for Adderall. On 13 and 18 May 2010 he tested positive for amphetamines. On 28 June 2010, he again tested positive for Adderall. Although this Soldier was administered Field Grade Articles 15 for every incident with the exception of one (self-enrolled in ASAP), he continues to serve on active duty after a pattern of illicit drug use spanning five years. It is unknown whether or not administrative separation was initiated in accordance with AR 635-200.

b. Reducing High-Risk Behavior

Chapter I introduced surveillance, detection and response to high-risk behavior in an effort to reduce the high-risk population across the Force. It also highlighted the two critical aspects of the commander's response: (1) to first promote the health and welfare of the Soldier and Family and (2) to hold the Soldier accountable for acts of high-risk behavior as appropriate. The first aspect is covered in Chapter II, while the second is the focus of this chapter. Although high-risk behavior is complex (as discussed above), commanders must respond to “any behavior that places the individual or others in danger or harm’s way.”²⁵²

To be effective, commanders must be clear in their intent to reduce high-risk behavior across the Force, clear in their application of disciplinary and administrative measures to enforce Soldier accountability, and clear in their adjudication of an act that—after weighing all mitigating and extenuating circumstances—placed the Soldier or others in danger or harm’s way. It is current Army policy that—

- “Commanding officers exercise broad disciplinary powers in furtherance of their command responsibilities. Discretion, fairness, and sound judgment are essential ingredients of military justice.”²⁵³
- “Commanders will familiarize themselves with their powers and responsibilities as outlined in the Manual for Courts-Martial (MCM), AR 27-10, AR 600-20, AR 600-37, AR 635-200, and other authorities. Legal advice is available from supporting judge advocates.”²⁵⁴
- “Commanders considering nonjudicial punishment should consider the nature of offense, the record of the [Soldier], the needs for good order and discipline and the effect of the nonjudicial punishment on the [Soldier] and the [Soldier’s] record.”²⁵⁵
- “Disciplinary measures are tailored to specific offenses and individual offenders. Commanders will neither direct subordinates to take particular disciplinary actions, nor unnecessarily restrict disciplinary authority of subordinates (see Articles 37, and 98, UCMJ, and AR 27-10 regarding the proper exercise of authority by commanders).”²⁵⁶

Consistent implementation of disciplinary and administrative policy by commanders has improved almost every facet of Soldier accountability over the last few years. Statistical analyses throughout this chapter indicate that while HQDA is reducing policy and program gaps, commanders are enforcing Army standards. In many cases, data concerning high-risk behavior are approaching historic norms. Commanders must continue this focused effort to ensure that progress is not lost. Because Soldiers exhibiting high-risk behavior may not be seen in all formations, the data presented below does not

always resonate at the unit level. With a force of over 700,000 Soldiers, individual actions viewed in isolation (i.e., seen only by a few commanders) can often paint a misleading picture. This chapter therefore takes a macro view of high-risk behavior to demonstrate the cumulative impact of this behavior on the Force.

LEARNING POINTS

- ➊ In accordance with AR 600-20, *Army Command Policy*, “Commanders will familiarize themselves with their powers and responsibilities as outlined in MCM, AR 27-10, AR 600-37, AR 635-200, and other authorities. Legal advice is available from supporting judge advocates.”
- ➋ The Army’s Risk Reduction Program (within AR 600-85) lists 21 risk factors that commanders and program managers need to monitor; more than half of these factors are associated with criminal misconduct which means that reducing misconduct will reduce Soldier and unit risk.
- ➌ Recognizing the potential criminality in high-risk behavior is essential because the role of the commander in correcting these behaviors is that of both investigator and judge.

3. Status of Discipline in the Force

Serious crime is clearly a moral issue— inconsistent with Army values—that imparts a moral obligation on leaders to uphold accountability. It impacts Army and unit readiness in a variety of ways both tangibly and intangibly. First, it impacts both the readiness of the offender and the victim, especially for violent crimes which can have a long-term, if not permanent, effect on the future readiness of both individuals. Second, crime has a tremendous financial impact on readiness including costs associated with short-term reparation and replacement of materiel items, but also human costs associated with longer term reparation and replacement of Soldiers who require medical intervention and rehabilitation or replacement of Soldiers separated from service (administratively, incarcerated, medically or from loss of life). Third, it erodes unit and team cohesion as well as individual and Family trust. Small units and, particularly, squads and teams, are the building block of the Army and crime at this level can have both a tangible and intangible impact on Army readiness. Finally—and perhaps the most intangible—is the cost to the Army’s reputation and sacred trust owed to the Nation.



“Trust is the bedrock of our honored profession -- trust between each other, trust between Soldiers and leaders, trust between Soldiers and their Families and the Army, and trust with the American people.”²⁵⁷

— GEN Raymond T. Odierno
Chief of Staff, Army
Expectations for the Future

It is essential that the Army preserve its reputation through leadership that enacts policy and programs that proactively prevent, mitigate, and promptly respond to criminal acts and high-risk behavior. Crime has an immediate impact on trust and reputation, but failure to respond appropriately has an even greater impact. Although the impact of crimes by Soldiers in uniform has a more palpable impact on Army trust and reputation, crimes committed by Soldiers who are AWOL or in deserter status, or crimes committed by Soldiers long separated still resonate as Service-connected offenses. The homicides committed by SSG Calvin Gibbs while serving in combat or the attempted homicides by Brandon Barrett while AWOL, were widely covered by the media as Soldier-related crimes. The

egregious nature of these crimes or those crimes allegedly committed by MAJ Nidal Hassan or SGT John M. Russell significantly eroded the Army's reputation. Even time and distance from active service still has a puzzling impact on popular media and public perception. The horrific crimes committed by John Allen Muhammad (DC sniper) and Timothy McVeigh (Oklahoma City bomber), long separated from the Army before the commissions of their crimes, nonetheless were touted in the media as former Soldiers. If nothing else, these crimes inform Army leaders of the fragility of trust and reputation. And though leaders can do little to affect post-service criminal acts, it is an impactful lesson that readily applies to those still serving.

Finally, crime—all crime—is transmittable both vertically and horizontally. It is transmittable vertically in the individual through the escalation from one crime to subsequent crimes and from minor infractions to increasingly more serious acts. This is most notable among drug offenses where habits feed dependence or addiction, eventually culminating in other crimes such as theft or robbery to satisfy its demand. This is equally true of high-risk behavior, with each act resulting in desensitization to policy, regulations and laws. In other words, once the line is crossed it becomes easier to cross the next time. Of greater concern to the Army is the horizontal transmission of crime to others, which is ironically facilitated by the same team cohesion that it erodes. Again, illicit drug use, but also sex crimes and larcenies are notable examples where a single individual will often transmit their acts of high-risk behavior and crime to others. These crimes will often have multiple offenders as part of a single crime event.

LEARNING POINTS

- ★ Crime is transmittable both vertically and horizontally. It is transmittable vertically in the individual through the escalation from one crime to subsequent crimes and from minor infractions to increasingly more serious acts; it is transmitted horizontally to others, which is ironically facilitated by the same team cohesion that it erodes.
- ★ Crimes committed by Soldiers who are AWOL or in deserter status, or crimes committed by Soldiers long separated still resonate as Service-connected offenses.

a. Crime in FY2011

In order to fully describe trends and the significance of these trends on the Army, this section describes Army crime in a variety of ways. The number of offense counts (or offenses) provide an overview of the total volume of crime (i.e., the total number of crimes that were committed in any stated year) while unique offenders examines individual Soldiers who are committing these crimes. Where appropriate, these numbers are normalized to rates per 100,000 Soldiers to account for minor changes in the Army population. By examining these factors, individual behavior (i.e., escalation of offenses, repeat offenders, crimes per unique offender, etc.) can be more easily described. While the total offender population is small (in the context of the entire Army), it has a profound effect on Army readiness.

In FY2011, there were a total of 78,262 offenses committed by active duty Soldiers (data for crimes committed by RC Soldiers while not on active duty are not currently captured by DA databases). The offenses are divided into three major categories including violent felony, non-violent felony and misdemeanor (as depicted at figure III-2). The total number of offenses included 2,811 violent felonies, 28,289 non-violent felonies and 47,162 misdemeanors. These major crime categories are further broken down into sub-categories to convey the scope and nature of these crimes.

Between FY2010-11, violent felonies increased by 1%, non-violent felonies increased by 11%, while misdemeanors decreased by 2%. These trends are consistent among the unique Soldier offender population; with violent felony offenders increasing by 4% (to 1,904), non-violent felony offenders increasing by 2% (to 16,074) and misdemeanor offenders decreasing by 3% (to 31,567).

The difference in the numbers of offenses and offenders reflect the fact that some offenders may commit multiple offenses in a single crime event or across multiple crime events (e.g., 5,769 drug offenders committed 11,265 drug offenses). This also accounts for the discrepancy between the sum of unique offenders in each sub-category and the totals provided for each main category in the chart. In other words, the numbers of offenders in the sub-categories will not add up to the totals provided in each of the

Crime Types and Categories	FY11 Offenses	FY11 Unique Offenders
Violent Felony	2,811	1,904
Homicide	139	105
Murder	65	56
Voluntary Manslaughter	3	3
Involuntary Manslaughter	24	20
Negligent Homicide	11	9
Attempted Murder	36	23
Sex Crimes	1,313	867
Rape	515	419
Aggravated Sexual Assault	414	374
Forcible Sodomy	349	280
Attempted Rape	29	29
Attempted Agg. Sexual Assault	6	6
Kidnapping	69	43
Robbery	87	45
Aggravated Assault	920	764
Child Pornography	283	194
Non-Violent Felony	28,289	16,074
Drug Crimes	11,265	5,769
Failure to Obey General Order	6,173	4,849
Desertion	1,939	1,673
Larceny	1,776	1,431
Government Property/Funds	1,068	916
Private Property/Funds	708	567
Other Sex Crimes	977	664
Drunk Driving with Personal Injury	76	73
Other Non-Violent Felonies	6,083	4,822
Misdemeanor	47,162	31,567
Traffic Violations	22,689	16,814
Assault and Battery	5,126	4,679
AWOL	4,316	3,155
Drunk Driving without Personal Injury	3,932	3,769
Family Abuse	2,771	2,428
Drunk and Disorderly	2,234	2,052
Other Misdemeanors	6,094	5,090
Total	78,262	42,698

Figure III-2: FY11 Offenses and Offenders

colored bars (gold and blue bars). The total number of offenders reflects unique Soldier offenders and, therefore, counts Soldiers who committed multiple crimes in FY2011 only once. So, whether a Soldier committed multiple offenses in a single crime event or multiple offenses across multiple crime events throughout the year, he / she is only counted once in the total offender counts for FY2011. This is an important point (as discussed under *Multiple Felony Offenders* in Section 3.c.): unique multiple offenders reflect the main source of recurring crimes; eliminating that source may eliminate multiple crimes and prevent future victimization of others.

(1) Violent Felony

Violent felony crimes made up 4% of all crime in the Army in FY2011.

Though the number as a percent of all crime is small, its impact has a far-reaching effect on Army communities, units, Soldiers and Families. For example, the number of individual victims directly impacted by violent felonies was 1,801 in FY2011 alone.

The table at figure III-3 lists all additional violent felony offense counts and rate of occurrence per 100,000 Soldiers. It also outlines the distribution of offenses for each sub-category under “percent composition” in the last column. This distribution of violent crimes provides perspective with respect to policy and programs governing surveillance, detection and response. The top five violent felony offenses committed by Soldier offenders in FY2011 were aggravated assault, rape, aggravated sexual assault, forcible sodomy and child pornography. The prevailing distribution of these crimes is consistent with previous years from FY2006-10. Sex crimes lead all major violent crime categories followed closely by aggravated assault. The last sub-category, child pornography, is closely related to the violent sex crime category as it represents sexual exploitation of a child.

A further analysis of the table also provides a few key sub-categories that require additional clarification:

- **Homicide and Attempted Murder:**⁸ Homicides include murder, voluntary and involuntary manslaughter, and negligent homicide. Attempted homicide is included under homicide because the common element of intent makes it appropriate to consider in tandem with homicide. When taken together, there were 139 homicide offenses in FY2011, including 4 murder-suicides (+ 2 incidents of murder-attempted suicide). There were 36 attempted murders in FY2011 alone.
- **Violent Sex Crimes:** The violent sex crime category (rape, aggravated sexual assault, forcible sodomy, attempted rape and attempted aggravated sexual assault) accounted for almost half (47%) of all violent felony offenses, with the offense of rape composing 39% of all violent sex crimes in FY2011.

Crime Categories	FY11 Offenses	Offenses Per 100,000	Percent Composition
Homicide	139	20	5%
Murder	65	9	2%
Voluntary Manslaughter	3	0	0%
Involuntary Manslaughter	24	3	1%
Negligent Homicide	11	2	0%
Attempted Murder	36	5	1%
Sex Crimes	1,313	186	47%
Rape	515	73	18%
Aggravated Sexual Assault	414	59	15%
Forcible Sodomy	349	49	12%
Attempted Rape	29	4	1%
Attempted Agg. Sexual Assault	6	1	0%
Kidnapping	69	10	2%
Robbery	87	12	3%
Aggravated Assault	920	130	33%
Child Pornography	283	40	10%
Total - Violent Felony	2,811	399	100%

Figure III-3: FY11 Violent Felony Offenses

⁸ For purposes of this report, attempted murder was included with homicides but data analysis is presented separately. Attempted murder was binned with homicides because it is closely associated through the element of intent. Every attempted murder represented a real potential for the completed act of murder.

- Child Pornography: There were 283 child pornography offenses in FY2011, making child pornography the fifth largest violent felony sub-category.
- Kidnapping: This crime is essentially the act of holding and moving (luring, enticing, transporting away) the victim against the individual's will. There were 69 kidnapping offenses in FY2011.

VIGNETTE—IMPACT OF VIOLENT FELONIES

In August 2011, a CPT entered his estranged wife's residence and shot and killed her, her boyfriend and the boyfriend's eight-year-old son. The following day, the CPT and his six-year-old daughter drove to his mother-in-law's house. After forcibly entering the house, he then shot and killed his mother-in-law. The CPT then attempted to leave his daughter at a local hospital along with a note to his daughter. When confronted by hospital staff he produced a handgun and departed. Following a traffic stop by local police later that day, the CPT shot and injured two officers. He also fired at other officers as they pursued him on foot. He killed himself before he could be apprehended.

Aside from the stress of a pending divorce, the CPT was receiving behavioral health care on a monthly basis for depression, anxiety and sleeping problems. He was prescribed Lunesta (sleep aid) and Zoloft (anti-depressant). His doctor stated that a large component of his condition revolved around ongoing marital problems.

(2) Non-Violent Felony

Non-violent felony crimes made up 36% of all crime in the Army in FY2011. This category also has a real impact on the Force in terms of victimization and readiness. The majority of these are crimes against the government with an impact measured in dollars, ranging from crimes costing millions of dollars (on the high side) to those costing \$5,000 (and below).

Crime Categories	FY11 Offenses	Offenses Per 100,000	Percent Composition
Drug Crimes	11,265	1,597	40%
Failure to Obey General Order	6,173	875	22%
Desertion	1,939	275	7%
Larceny	1,776	252	6%
Government Property/Funds	1,068	151	4%
Private Property/Funds	708	100	3%
Other Sex Crimes	977	139	3%
Drunk Driving with Personal Injury	76	11	0%
Other Non-Violent Felonies	6,083	862	22%
Total - Non-Violent Felony	28,289	4,011	100%

Figure III-4: FY11 Non-Violent Felony Offenses

The top five non-violent felony offenses committed by Soldiers in FY2011 were drug crimes, failure to obey general order, desertion, larceny (government and private property / funds) and other sex crimes. With the exception of their rank order, these top five are consistent with prior years FY2006-10 with desertion and larceny trading places (desertion moving up to the third position in FY2011). The table at figure III-4 lists all non-violent felony offense counts and the rate of occurrence per 100,000 Soldiers. The table also outlines the distribution of offenses for each sub-category under non-violent felony offenses. This distribution provides additional perspective on the composition of Army non-violent felony crimes.

Again there are several key crime sub-categories that require further review:

- Drug Crimes: There were 11,265 drug offenses committed by 5,769 unique Soldiers in FY2011. Drug offenses include both illicit use of street drugs (e.g., heroin, cocaine, marijuana) and illicit use of prescription medication (e.g., amphetamines, oxys and barbiturates).
- Failure to Obey: There were 6,173 Failure to Obey offenses in FY2011. These include possession of drug paraphernalia, underage drinking and weapon violations, among others.
- Desertion: There were 1,939 desertions Army-wide, which most commonly is the failure of an AWOL Soldier to return within 30 days. The key distinction is that desertion is an escalation from an AWOL status, from a misdemeanor to a felony crime. Deserters remain in felony status until returned to Army control and formally out-processed from the Army.
- Other Sex Crimes: These include additional sex crimes under Article 120 of the UCMJ that were not included in the violent crime category such as abusive sexual contact, aggravated sexual contact, wrongful sexual contact and indecent acts. There were 977 other sex crimes committed in FY2011.
- Other Non-Violent Felonies: This category captures all other non-violent felonies including bigamy, forgery, impersonating an officer, false official statement, false claims, etc. There were 6,083 other non-violent felonies committed in FY2011.

While violent felonies are generally investigated by CID and misdemeanors are generally investigated by Military Police Investigators (MPI), non-violent felonies may be investigated by CID and MPI and, under some conditions, by commanders as a part of an AR 15-6 investigation. AR 195-2, *Criminal Investigation Activities*, soon to be re-titled *Criminal Investigative Activities and Operations*, establishes the thresholds for investigative jurisdiction whether CID, MPI or commanders. For example, while CID will generally investigate serious fraud (>\$5,000), MPI will investigate lesser fraud and larceny (<\$5,000 to >\$1,500), and commanders will investigate barracks larceny (<\$1,500). Other examples of the stratification of investigative jurisdiction may include the fact that CID investigates all false official statements in conjunction with a more serious offense, while MPI investigates all other instances of false official statements; CID investigates all instances of assault consummated by battery on a child under the age of 16 years, while MPI investigates all simple assaults with hospitalization, while commanders investigate simple assaults occurring within the unit area that do not result in hospitalization. These stratifications are outlined at Appendix B, Table B1, titled *Offense Investigative Responsibility*, which provide an equitable investigative workload to ensure that CID and, to a lesser extent MPI, can focus on the timely investigation of more serious crime.²⁵⁸ It is critical that leaders among these investigative sets collaborate to ensure coverage of all criminal and high-risk behavior.

(3) Misdemeanor

Misdemeanor crimes made up 60% of all crime in FY2011. This category has a lesser impact on the health and readiness of victims but, nevertheless, takes a toll in terms of time and resources that must be committed in the adjudication of 47,162 misdemeanors. As mentioned earlier, misdemeanor offenses subtly decreased in FY2011. It should be noted, however, many misdemeanor offenses are administratively adjudicated by commanders (through non-judicial punishment and other means) and not reported to law enforcement or included in this data. This policy is consistent with prior years and though visibility of non-reported offenses would demonstrate a much larger number in each year, minor changes in reporting year-over-year should not impact any overall trends. Although the Army had considered creating a centralized database for AR 15-6 investigations to increase situational awareness, the consideration was rightly discarded to preserve the integrity of command authority regarding adjudication and reparation for lesser crimes at local levels.

The top five misdemeanor offenses committed by Soldiers in FY2011 were traffic violations, assault and battery, AWOL, drunk driving without personal injury and family abuse. The table at figure III-5 lists all misdemeanor offense counts and the rate of occurrence per 100,000 Soldiers. The table also outlines the distribution of offenses for each sub-category under misdemeanor offenses. Although, misdemeanors often represent minor infractions (traffic violations) their impact cannot be overstated. Misdemeanors provide potential indicators to gauge both the health and discipline of the Force, especially among Soldiers who commit more serious misdemeanor offenses. For example, drunk and disorderly or DUI both provide a potential indication of a Soldier who may be struggling with a health issue related to alcohol dependence, and is engaging in high-risk behavior with potential for serious outcomes, such as personal injury. Again, these types of infractions provide an opportunity for commanders to fully assess the health and welfare of the Soldier to appropriately counsel and mitigate any future adverse outcomes.

Crime Categories	FY11	Offenses	Percent
	Offenses	Per 100,000	Composition
Traffic Violations	22,689	3,217	48%
Assault and Battery	5,126	727	11%
AWOL	4,316	612	9%
Drunk Driving without Personal Injury	3,932	557	8%
Family Abuse	2,771	393	6%
Drunk and Disorderly	2,234	317	5%
Other Misdemeanors	6,094	864	13%
Total - Misdemeanor	47,162	6,686	100%

Figure III-5: FY11 Misdemeanor Offenses

VIGNETTE—PATTERN OF DOMESTIC VIOLENCE

A 44-year-old SGT returned in March 2010 from his third combat deployment. Ten days later, he was arrested by civilian law enforcement after a physical altercation with his girlfriend. He was arrested a second time for physically abusing his girlfriend in November 2010. No disciplinary or administrative action was taken against the SGT for either incident. In December 2010, the SGT had difficulty coping with the death of his son who was killed in a gang-related incident, even denying to unit members that his son had died. In May 2011, he murdered his girlfriend, shooting her five times and then unsuccessfully attempted to kill himself by shooting himself in the head. He is now a paraplegic.

Traffic violations, too easily dismissed, provide a good example of misdemeanor level indicators of high-risk behavior. Command visibility of traffic violations may inform proactive measures that could prevent unintentional but serious outcomes such as involuntary and negligent homicide or accidental deaths. In fact, since FY2006 653 Soldiers (from 403 vehicle and 250 motorcycle accidents) have lost their lives.²⁵⁹ Among the 85 vehicle fatalities in FY2011, moreover, 16% had received prior moving vehicle citations from military law enforcement. Unfortunately, commanders often do not obtain a complete picture of any individual Soldier's behavior because while traffic violation information is provided to them via DD Form 1408 (Armed Forces Traffic Ticket), military law enforcement rarely provides information regarding more serious traffic offenses which are recorded on the DD Form 1805 (US District Court Violation Notice).

While fifth on the list of misdemeanor offenses in FY2011, family abuse is an area that needs focused attention. Family abuse may be an underreported offense due to the fact that law enforcement often categorizes incidence of family abuse under a variety of other assault-related charges. This

oversight has not been corrected through standard policy implementation since the publication of the *Red Book* which reported:

“Law enforcement personnel may choose to enter the offense code for assault rather than for spouse abuse, administratively reducing the total number of reported cases to law enforcement. As a result, law enforcement may not have full situational awareness of domestic violence on the installation or how commanders are adjudicating these actions.”²⁶⁰

Additionally, underreporting of family abuse may have more serious implications than previously thought. As discussed in Chapter II under *Post Traumatic Stress (PTS) and Post Traumatic Stress Disorder (PTSD)* and *Depression* sub-sections, Soldiers suffering from behavioral health issues including PTSD and depression have been shown to have higher incidence of partner abuse. For example, male Soldiers with PTSD are up to three times more likely to demonstrate aggression against their female partners.²⁶¹ Likewise, “...for each 20% increase in depressive symptoms, there was a 74% increase in the likelihood of husband-to-wife aggression.”²⁶² These research findings underscore the importance of accurately reporting family abuse to commanders and Family Advocacy Program (FAP) counselors and may indicate a need to screen Soldiers who commit family abuse for PTS and depressive symptoms.

VIGNETTE—DRUGS AND ALCOHOL ASSOCIATED WITH CHILD ABUSE

Two months following his redeployment in September 2009, a 26-year-old SGT drank excessively and took painkillers prescribed to his wife. He sexually assaulted his step-daughter and then murdered her. His behavioral health history could not be determined but media reported that he suffered from severe PTSD following an IED incident which killed fellow Soldiers.

The SGT’s attorney argued that his PTSD and drug and alcohol abuse affected his judgment and therefore his intent during the homicide. The jury found him guilty of first degree murder and sexually assaulting the child but was unable to reach a unanimous verdict on sentencing. As a result, the judge sentenced the SGT to life in prison without the possibility of parole.²⁶³

LEARNING POINTS

- ★ There were 42,698 offenders (6% of the AD population) who committed over 78,000 offenses in FY2011 which included 2,811 violent felonies, 28,289 non-violent felonies and 47,162 misdemeanors.
- ★ Violent felony crime represented only 4% of all crime (led by sex crimes) but represents the greatest impact on Soldier readiness.
- ★ Roles and responsibilities for investigating crime (CID, MP and commanders) are outlined in AR 195-2, Appendix B, Table B1; it provides clear guidance on investigative authority / jurisdiction.
- ★ Traffic violations provide a good indicator of high-risk behavior and community safety.

(4) Crime Demographics in FY2011

The table at figure III-6 shows active duty Soldier offenders by rank for the three crime categories in FY2011. There were 42,698 total offenders comprised of 1,904 violent felony offenders, 16,074 non-violent felony offenders and 31,567 misdemeanor offenders (*some Soldiers may be reflected in more than one category*). Junior Soldiers (E1-E4) make up only 43% of the active duty Army population but committed 68% of all crime in FY2011. This includes 68% of all violent felonies, 78% of all non-violent

felonies and 65% of all misdemeanor crime. This equates to ~13,800 unique junior Soldiers who committed violent and non-violent felonies and another ~20,600 who committed misdemeanors. Junior Soldiers were followed by NCOs (E5-E6) who make up 28% of the Army and who committed 22% of all crime, with 24% of all violent felonies, 16% of all non-violent felonies and 23% of all misdemeanor crimes. Together, these two groups (E1-E6) make up 71% of the Army, were responsible for 90% of all crime in FY2011.

FY11 Unique Offenders by Crime Type and across All Crime Types

Grade	Violent Felony		Non-Violent Felony		Misdemeanor		All Crime Types		vs. FY11 AD
E1-E4	1,298	68%	12,504	78%	20,629	65%	29,085	68%	43%
E5-E6	455	24%	2,580	16%	7,344	23%	9,217	22%	28%
E7-E9	83	4%	453	3%	1,497	5%	1,859	4%	12%
W01-CW5	12	1%	75	0%	309	1%	367	1%	3%
O1-O3	39	2%	261	2%	1,246	4%	1,447	3%	8%
O4-O6	11	1%	117	1%	472	1%	570	1%	6%
Unknown*	6		84		70		153		
Total	1,904	100%	16,074	100%	31,567	100%	42,698	100%	~100%

* Omitted for comparison purposes to the AD population; AD population does not contain unknown numbers

Figure III-6: FY11 Offender Grade Composition

A distribution by rank and gender for victims of violent crimes in FY2011 is depicted in figure III-7. Victims were categorized as Soldiers, civilians, or unknown individuals. The Government, businesses, and other institutions were not considered as victims or included in the victim count, as crimes against these entities do not have the same deleterious effect on the readiness of the Force and the Army community.

- The overall number of Soldier and civilian victims was relatively equal. In addition to data reflected in this chart, the number of Soldier victims of the non-violent felonies of larceny and other sex crimes is higher than the number of civilian victims. This can be attributed to the fact that these types of crimes generally occur in a military environment.
- There were 147 individual victims who could not be definitively identified as a Soldier or a civilian, due to inconsistent connectivity between military and civilian law enforcement. Based on a sampling of incidents involving unknown victims, it is presumed that the majority of the unknown individual victims would be categorized as civilians.

Number of Unique Individual Victims of FY11 Violent Crimes

by Crime Category	Female	Male	Unknown	Total
Homicide	43	75	4	122
Sex Crimes	829	43	3	875
Kidnapping	37	13		50
Robbery	15	29		44
Aggravated Assault	283	402	103	788
Child Pornography	18			18

by Victim Type	Female	Male	Unknown	Total
Soldier	387	319		706
E1-E4	330	239		569
E5-E6	44	60		104
E7-E9	3	11		14
W01-CW5		3		3
O1-O3	5	6		11
O4-O6	1			1
Grade Unknown	4			4
Civilian	739	202	7	948
Unknown/Unreported	28	16	103	147
Total	1,154	537	110	1,801

Figure III-7: FY11 Victims of Violent Crimes

b. Crime Trends, a Comparison of Crime from FY2006-11

This section provides a comparative analysis of crime from FY2006-11 in order to inform senior Army Leaders, field commanders and program managers of notable trends that may inform surveillance, detection and response efforts. The trend analysis provides a more detailed perspective of the status of discipline in the Army in FY2011 as compared to previous years and includes comparative analysis against national crime, then moves to discuss trends among the three major crime categories and trending of illicit drug use, sexual crimes, AWOL / desertion, and other indiscipline trends. With the exception of the national trends, which were analyzed by calendar year, all other trend analysis was conducted by fiscal year.

(1) National Comparison

This report cautiously approached making any national comparisons but provides deeper analysis using known Army data in pertinent subsections throughout this chapter. Similar to suicide data, national crime data lag the Army by two years as illustrated in figure III-8. For national comparisons, Army data was analyzed based on terms of reference outlined in the Uniform Crime Reports (UCR) to more closely approximate an apple-to-apple comparison (UCR conventions are not used elsewhere in this report).²⁶⁴ Data for national trends were adjusted based on age (18-44) but could not be adjusted for other relevant demographics.

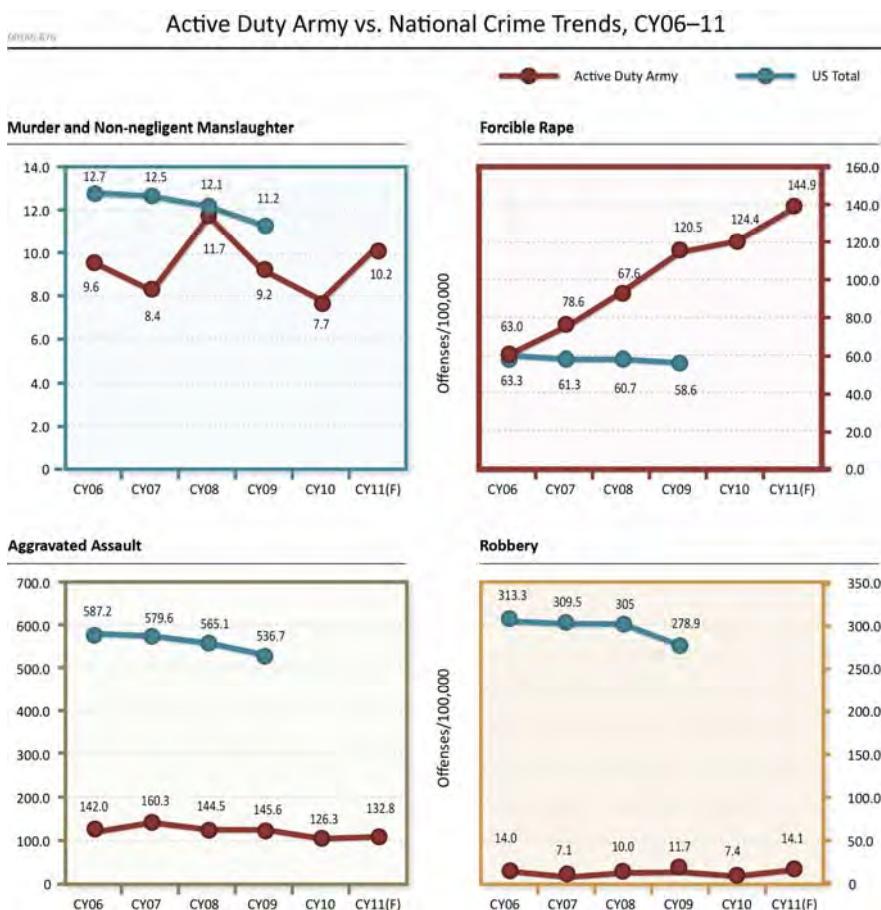


Figure III-8: Active Duty vs. National Crime Trends, CY06-11

When compared to national crime rates, the Army data demonstrate a somewhat dichotomous pattern. On one hand, Army crime rates in the categories of homicide (murder and non-negligent manslaughter), aggravated assault and robbery remain below national averages, while Army rates for rape remain consistently higher. These specific crimes were selected because they were the only crimes based on data collection that offered a relevant comparison (e.g., national drug offenses are based on arrest only, which would significantly underreport trends compared to a more robust Army surveillance program [drug testing]). Nevertheless, a comparison of these crimes still provides some insight into these two populations.

Murder and non-negligent manslaughter, which share the element of intent (figure III-8), include only those offenses involving a willful killing (includes Army data for voluntary manslaughter). The Army trailed national homicides in each year from CY2006-09 and, given the decrease in Army homicides in CY2010 and CY2011 (projected) this trend is expected to continue through CY2011. Army homicides (for these two categories) fluctuated from CY2006-11, while national homicides consistently trended downward in each year over the same period. The Army homicide trend appeared to remain below the national trend in each year with Army rates widely swinging from 11.7 to 7.7 per 100,000 compared to national rates from 12.7 to 11.2.

Forcible rape, as defined by the UCR, includes all carnal knowledge of a female by force and against her will. The Army led the national trend for this category of crime, increasing in each year from CY2006-11, while the national trend subtly declined year over year. The Army trend, moreover, increased at a rate that consistently widened the gap with the national trend from similar levels in CY2006 to more than double by CY2009. And again, given the Army's increase in violent sex crimes in CY2010 and CY2011 (projected) this gap can be expected to grow.

Aggravated assault is defined similarly for both UCR and Army data defining this crime as an attack by one person upon another to inflict grievous bodily injury. The national trend led the Army from CY06-09 consistently almost quadrupling the Army rate in each year. Both trends are subtly decreasing year over year with the Army continuing this trend in CY2010 and CY2011.

Robbery offenses are also defined similarly as the taking of anything valuable from another person by violent force or threat of violent force. The national rate significantly eclipsed the Army rate by more than 25 times per 100,000 in the same years. The national rate has trended downward from CY06-09 and though the Army rate increased in CY09 and CY11 the number of offenses (~73 annually) is too small to derive any significant conclusion.

(2) Overall, Violent / Non-Violent Felonies and Misdemeanors

This section highlights the trends for the three major crime categories based on annual comparisons from FY2006-11. Again, trends were analyzed on the basis of offenses and offenders per 100,000 Soldiers to normalize year-over-year fluctuations in the active duty population. The chart at figure III-9 provides the total offenses (blue) and total offenders per 100,000 (green) for all crime from FY2006-11. As discussed earlier, increases in both violent and non-violent felonies were the drivers in increasing overall crime rates. Although the overall crime rates rose in FY2011 (from a low in FY2010), rates remained below those from FY2007-09.

There are several interesting aspects to the increase in crime from FY2010-11, not all of which is bad news. Increases in desertion, AWOL and drug offenses did not generally impact others; the exception being drug distribution, which represented a small number of offenders. In other words, these crimes represent "self-destructive" high-risk behavior with few associated victims. Another interesting aspect was that the increase in overall criminal offenses outpaced the increase in unique Soldier offenders (438 vs. 92 per 100,000) indicating that fewer offenders are committing more offenses per crime event per year. Consequently, identifying these offenders and applying administrative and disciplinary measures (as appropriate) will have an immediate impact in reducing the number of overall offenses. Also, three of the four crime sub-categories (drugs, AWOL and desertion) which were key drivers to the increase in FY2011 were the primary drivers to the decrease in crime from FY2009-10. Increases in these types of crime tend to indicate an increase in command involvement and reporting rather than an increase in

actual crime. For example, identification and reporting of drug crimes and AWOL/desertion (or GO violations) are normally the result of command surveillance, detection and response.

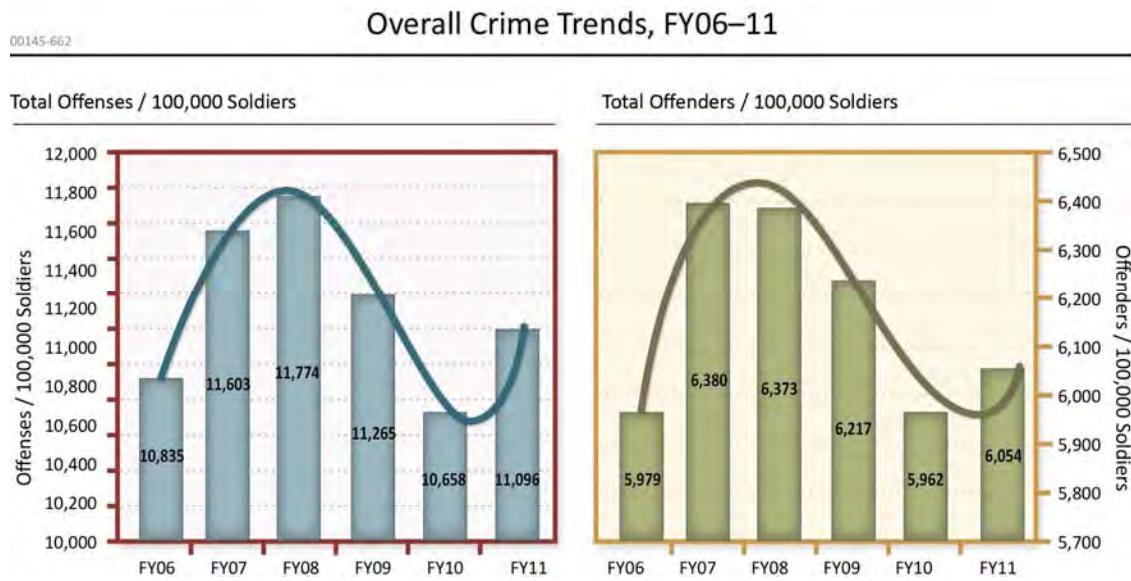


Figure III-9: Overall Crime Trends, FY06–11

VIGNETTE—LEGAL / INVESTIGATIONS ASSOCIATED WITH SUICIDE

A 40-year-old SSG failed to report to Warrant Officer Candidate School in September 2010. His unit reported the AWOL to law enforcement the next day and dropped him from the rolls the following month. Despite this action, he was promoted to SFC in February 2011 and continued to receive his pay. On 23 September 2011, his unit learned the SFC was at his residence (in a town adjacent to the installation) and took action to effect his return to military control. That evening, the SFC's daughter found him after he hanged himself in the family garage.

(a) Violent Felony Crime Trends

Violent felonies, as a subset of general crime, are increasing year-over-year as illustrated in figure III-10, reaching a new high in FY2011 to a rate of 399 offenses and 270 offenders per 100,000 Soldiers. This accounts for an overall increase of 31% in offenses and 24% in offenders between FY2006 and FY2011, including an increase of 3% and 6% in FY2011. And although the increase in the rate of offenders per capita was greater than that for offenses, the gap between offenders and offenses (270 vs. 399) also remained fairly consistent in each year. Consistently, Soldier offenders tend to commit multiple offenses, which scopes part of the problem—and the corresponding solution to discipline / separate—to this small sub-population.

Although violent felonies represent only 4% of total Army crime, their effects are often catastrophic when compared to general crime. This is certainly true of violent sex crimes, for example, which increased by over 90% from FY2006–11 (both offense and offender counts) and consistently remained the main driver for the overall increase in violent felony crimes each year. While it is too early to determine the full impact of recent changes in Army policy and process (e.g., a dramatic decrease in misconduct accession waivers followed by a dramatic increase in administrative separations), progress in current implementation can rationally be expected to counter current increases in violent crime.

Additionally, there is an expectation that proposed policy changes in draft (e.g., centralized flag process for Soldiers who commit multiple felonies, accelerated warrants for high-risk AWOLs, and increased command surveillance of barracks discipline) may also counter current trends in violent felony offenses.

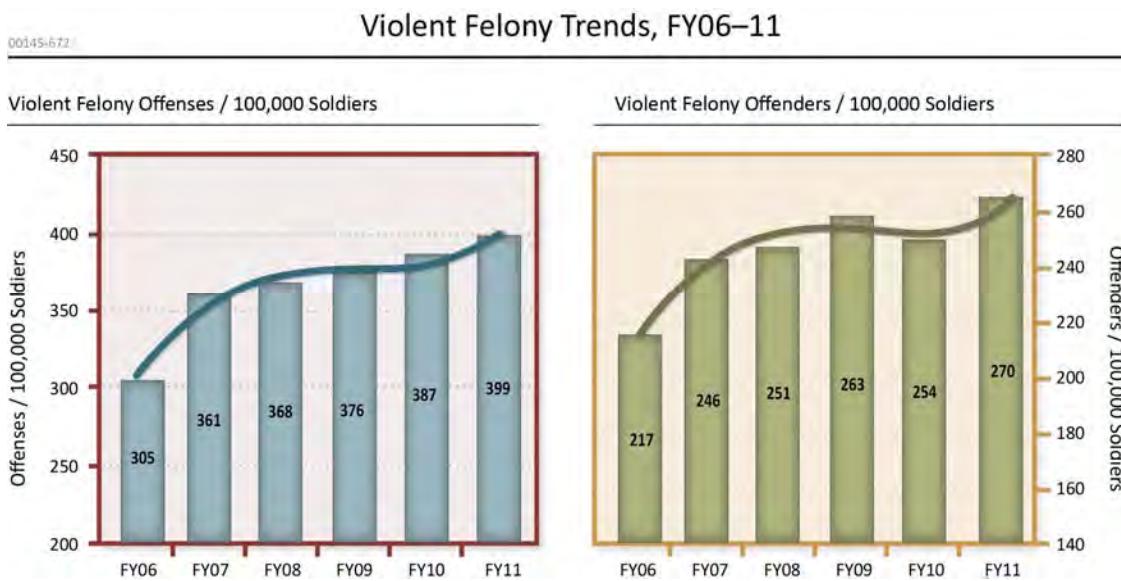


Figure III-10: Violent Felony Trends, FY06–11

The effect of crime on victims represents the best metric of its impact on the Force. By definition all crime is associated with a victim; whether government, other entity or unique individual victim. Unique victims of violent crimes are the most adversely impacted in terms of physical and emotional harm and naturally represent the greatest impact to the Army in terms of culture, readiness, unit cohesion and rehabilitation. As such, this particular set of victims is the only set reviewed in this report but the impact of violent crime may be generally inferred (to some degree) among victims of other crime categories.

VIGNETTE—ALCOHOL, EXTREME VIOLENCE AND SUICIDE

On 23 October 2011 a 26-year-old SPC was driving drunk, began arguing with his girlfriend, pulled over and began randomly firing his AR15 M4 into traffic from behind his car. An off-duty deputy, unaware of the activity, approached the SPC to render assistance. The SPC fired upon the deputy, hitting him nine times and killing him before turning the gun on himself and committing suicide. Evidence shows the SPC fired 42 rounds during entire incident.

The SPC was scheduled to complete MOS training on 26 October 2011, 3 days after this incident. Records show he self-enrolled in ASAP on 16 August 2011 and was receiving treatment for alcohol and marijuana dependence. ASAP completed a Suicide Risk Assessment on him and characterized him as low risk. During the investigation, his girlfriend stated he would get violent whenever he got drunk. His barracks room was found in a state of disarray. In a journal entry (found in room / entry date not known), the SPC discussed his life and hardships growing up and hardships dealing with events he witnessed in Iraq (2007) as well as his struggle with alcoholism. The entry contained no indicators of violence or suicidal ideations.

Victims of violent crimes have consistently increased from FY2006-11 (green bars), while offenders have shown a less marked increase (orange bars) as illustrated at figure III-11. Using FY2006 as the bench, the lines in figure III-11 demonstrate the percent of change among victims and offenders from FY2006-11. There was a 47% increase in the

number of unique victims from 1,223 in FY2006 to 1,801 in FY2011. The rate of increase between victims and offenders rose in tandem through FY2009 before diverging from FY2009-11. This indicates a trend where fewer offenders are committing crimes against more victims. Even when the Fort Hood incident is excluded (1 alleged offender and 53 victims), this gap between offenders and victims continued to increase through FY2011. For example, crimes committed by one offender against two victims rose by 18% from FY2009-11, while crimes committed by one offender against three victims rose by 40%.

There are two scenarios that explain this trend and are worth examining in the context of command surveillance and response. Specifically, is this trend the result of a single offender targeting unique victims across multiple events or it is the result of a single offender targeting multiple victims in a single event? The first scenario indicates the need for increased surveillance of and response to known repeat offenders or individuals exhibiting high-risk behavior over time, while the second indicates the need for increased surveillance of and response to environments that may be more conducive to collateral offenses or victimization (e.g., drinking in the barracks, family abuse, indiscriminate shooting spree). While there is no data to support one over the other, the detection of either requires continuous surveillance for indicators and an immediate and appropriate command response to mitigate in the potential for increased victimization.

(b) Non-Violent Felony Crime Trends

As noted previously, non-violent felony numbers (for both offenses and offenders) drove the majority of change seen in Army crime rates between FY2010 and FY2011. Looking back to FY2006, this represents a somewhat misleading statistic. The number of non-violent offenses and offenders had previously decreased, with precipitous drops in FY2009 and FY2010. In fact, as overall crime numbers decreased from their high in FY2008, non-violent felony offenses displayed the most consistent and significant decrease among all offense categories. In FY2011, however, non-violent felony crimes per capita reversed the downward trend with resultant increase of 13% and 4.2% in offenses and offenders respectively (as illustrated at figure III-12). Although the tick upward in FY2011 erased much of the progress made over the previous two years, non-violent felony rates remained below FY2006 levels. Additionally, the ratio of offenses per offenders has remained relatively consistent with offenders committing an average of 1.7 offenses per crime event.

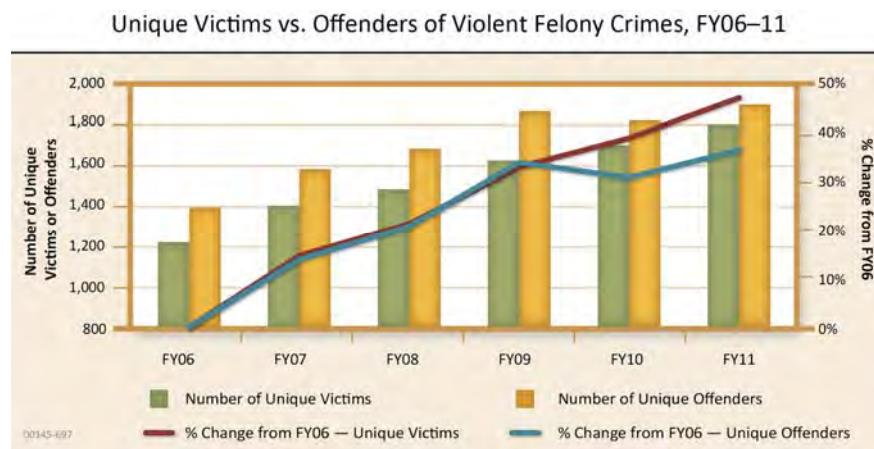


Figure III-11: Unique Victims vs. Offenders of Violent Felony Crimes, FY06-11

The non-violent felony sub-categories of Failure to Obey a General Order, drug crimes and desertion led the overall increase of 13% in non-violent felony offenses. These sub-categories, as measured by offense counts, increased 41%, 19% and 13% (respectively) in FY2011. However, known gaps in at least two of these subcategories (drug offenses and desertion) may be masking criminal reporting and, ultimately, may push non-violent felony crimes higher as gaps are reduced in the near future. These gaps and policy / program implications are addressed under their respective sub-sections, *Drug and Alcohol Crime Trends* (Section 3.b.(3)) and *AWOL / Desertion* (Section 3.b.(6)).

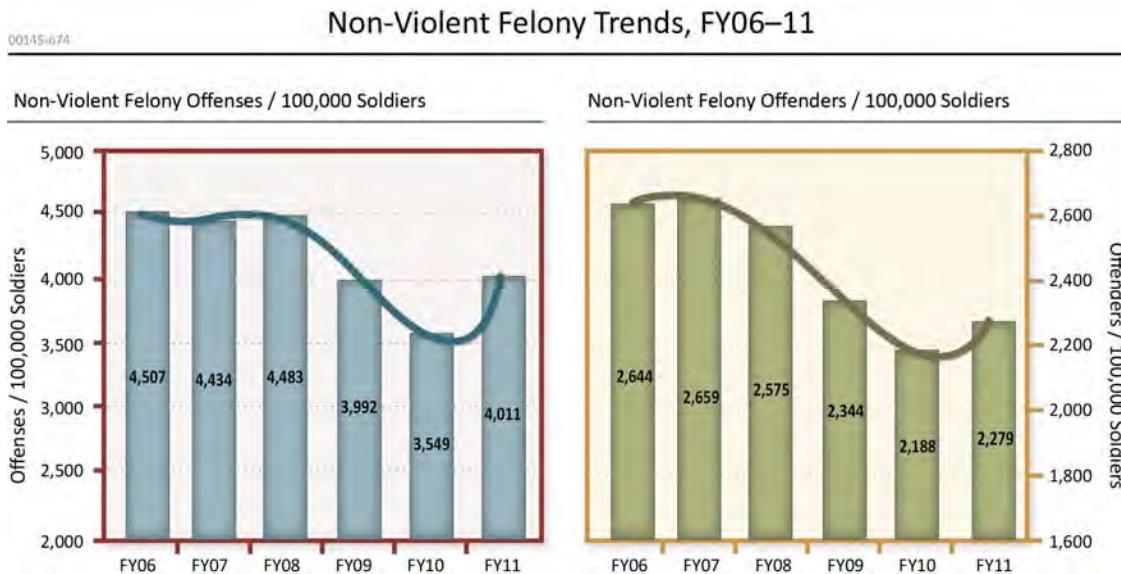


Figure III-12: Non-Violent Felony Trends, FY06–11

(c) Misdemeanor Crime Trends

Similar to overall crime trends, both misdemeanor offenses and offender rates peaked in FY2008 and have gradually decreased over the past three years. Unlike other crime categories however, misdemeanors did not show any increase between FY2010 and FY2011. After an initial and severe increase in misdemeanor crime rates between FY2006 and FY2008 (a specific increase of 13.0% among offense rates and 12.6% offender rates), both offenses and offenders decreased by 1.7% and 5.5% respectively. There were a total of 273,206 offenses committed by 186,299 offenders in this period, of which, traffic violations composed 45% (121,673 of 273,206) of all offenses. If traffic offenses are excluded, there were 151,533 offenses committed by 93,172 offenders. As discussed earlier under Crime in FY2011, misdemeanor offenses are a good indicator of the status of discipline across the Force.

A few misdemeanor crime subcategories stand out during this period. AWOL offenses increased by 14.7% (to a total of 28,615) and increased by 4.2% (from 587 to 612) per 100,000 from FY2006–11. In FY2011, this trend culminated in a strong uptick in offenses and offenders of 12.9% (from 542 to 612) and 5.1% (from 425 to 447) per capita. This discrepancy between offenses and offenders clearly indicates a subset of repeat AWOL offenders that continue to impact individual and unit readiness, consume leaders' time and expend Army resources.

Also, family abuse increased in the same period with offenses up 61% (from 244 to 393) and offenders up 56% (from 221 to 344) per capita in FY2006–11. However, in FY2011 family abuse offenses and offenders decreased by 7.8% (3,007 to 2,771) and by 7.3% (from 2,618 to 2,428). The increase and

subsequent decrease in this crime subcategory may reflect a decrease in familial stress as the Army continues to improve its dwell time and Family programs and services.

On a positive note, drunk and disorderly offenses / offenders have trended downward per capita from FY2006-11. Drunk and disorderly offenses / offenders decreased 15.7% (2,409 to 2,234) and 15.1% (2,197 to 2,052) per capita from FY2006-11. DUI offenses / offenders also trended downward per capita in the same period (though the number of offenses / offenders increased marginally). DUI offenses / offenders decreased by 7.4% and offenders decreased by 7.1% per capita however, the actual numbers of offenses / offenders increased slightly from 3,857 to 3,932 and 3,687 to 3,769.

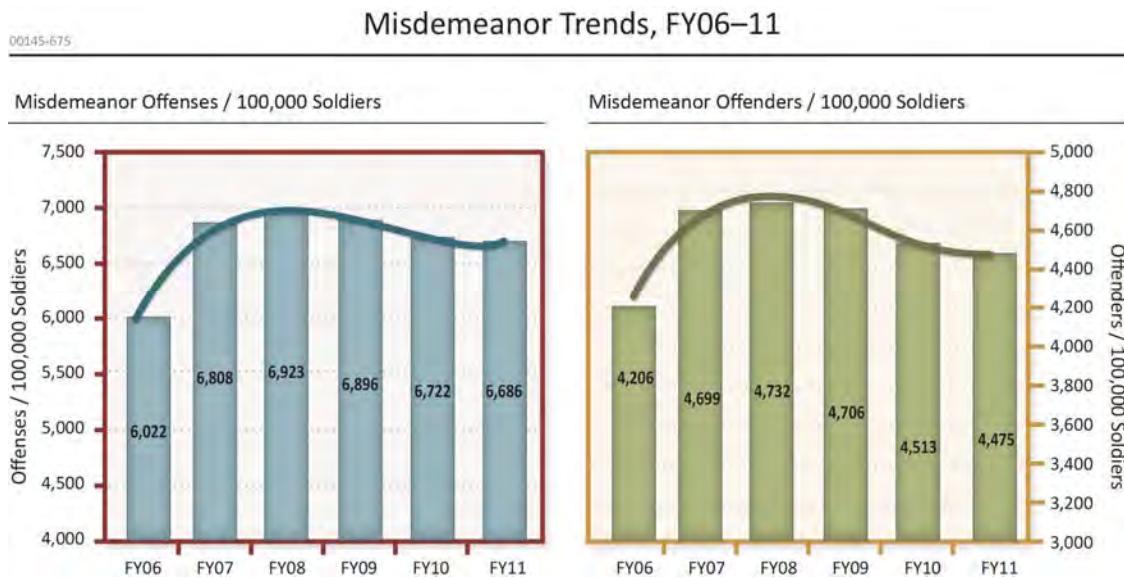


Figure III-13: Misdemeanor Trends, FY06–11

(3) Drug and Alcohol Crime Trends

On 9 September 2011, USA Today featured an article about the growing prevalence of recreational drug use nationally. This criminal trend mirrors an increasing drug and alcohol health trend highlighted in Chapter 2 (e.g., the health risks associated with polypharmacy and pain management, binge drinking). The USA Today article stated that “[n]early 1 in 10 Americans report regularly using illegal drugs, including marijuana, cocaine, heroin, hallucinogens, inhalants or prescription drugs used recreationally, according to the National Survey on Drug Use and Health.”²⁶⁵ The article cited a SAMHSA study that included data from 67,500 interviews of randomly selected individuals 12 years and older. The study found that drug use was on the rise, predominantly among college-age adults, and was primarily driven by an increase in marijuana use. With marijuana use increasing from 5.8% (in 2007) to 6.9% (in 2010), it is estimated that approximately 17.4 million Americans regularly use marijuana. Common speculation attributes the increase in use to a change in public perception as an increasing number of states have legalized marijuana use for a variety of medical therapies.

External societal trends can impact the Army in multiple ways across all Army demographics. More permissive attitudes toward the recreational use of prescription medication and marijuana use affect the recruiting population, external treatment programs accessed by Army Soldiers (e.g., TRICARE, Military OneSource, TRIAP) reduce potential behavioral health surveillance and emerging societal trends can be readily introduced to the Force as the Army mobilizes the RC population. The relaxed perception

toward marijuana use, for example, may explain a dramatic increase in its use among the RC population who were tested from FY2006-11. Usage rates among this population increased by 89% (among ARNG Soldiers) and by 73% (among USAR Soldiers) as compared to an overall 17% decrease among AD Soldiers during this same period. Such influences, compounded by existing gaps in Army drug and alcohol surveillance, detection and response systems will continue to exert pressure on the discipline of the Force.

VIGNETTE—INEFFECTIVE RESPONSE

A 28-year-old SSG failed to report to work in July 2011 and a search of his off-post residence failed to locate him. Civilian law enforcement officers subsequently found a Hydroponic Marijuana Growth System and marijuana with an estimated street value of \$73,000 in his residence. He was titled for cultivation of marijuana while AWOL and was subsequently dropped from the rolls as a deserter. He remains a fugitive with an active deserter warrant in effect.

A review of his criminal background revealed the following crime history: Domestic violence (2004) resulting in anger management and marital counseling; DWI (2005) with no action taken and with no referral to ASAP; driving with a suspended license (2005); DUI (2010) resulting in a letter of reprimand (OMPF), suspended driving privileges and a referral to ASAP.

Army leaders continue to make significant progress in drug and alcohol surveillance, detection and response systems when viewed from a holistic perspective. With the exception of a minor increase in drug crimes in FY2011, active duty drug and alcohol crimes have declined since FY2006. Even with the minor increase in FY2011, drug crimes remain below the FY2006-10 average. Other policy and program metrics indicate consistent improvement in drug and alcohol surveillance, detection and response systems, including drug testing, drug and alcohol referrals, drug and alcohol treatment and drug and alcohol administrative actions. Though this report still found gaps in drug and alcohol systems (as outlined below), the Army continues to reduce their impact through new policy; increased policy implementation; and improvements in the quality, fusion and sharing of drug and alcohol data.

Army leaders understand the need to fully close current policy and program gaps associated with drug surveillance, detection and reporting. They are addressing these gaps but implementation will take time and, until policy is fully executed, we can expect potential underreporting. Conversely, as gaps are closed, we can expect temporary spates in drug crime reporting as a result of improved surveillance. For example, the Army failed to test 89,310 AD Soldiers in FY2011 alone. Although the number of untested Soldiers is on the decline year over year, untested Soldiers in FY2011 would still account for an additional 902 drug offenses that went undetected. As noted in this example, closure of the testing gap in late FY2010 would have created a spate in drug crime reporting of 16% in FY2011. The potential impact on reporting as a result of closing just this one gap, reveals the potential magnitude that under-reporting (to some degree) has on command surveillance, discipline and accountability.

LEARNING POINTS

- ★ Army crime rates in the categories of homicide (murder and non-negligent manslaughter), aggravated assault and robbery remain below national averages, while the increase in Army rates for rape demonstrates a widening gap with the national average.
- ★ Violent felony offenders in the Army increased by 24% from FY2006-11, while non-violent felony and misdemeanor offenders have decreased since FY2008.

- ★ Junior Soldiers (E1-E4), who make up only 43% of the active duty Army population, committed 68% of all crime in FY2011.
- ★ Consistently, Soldier offenders tend to commit multiple offenses, which indicate a need for increased surveillance and a more consistent response.
- ★ Despite a minor increase in drug crimes in FY2011, AD drug and alcohol crimes have declined since FY2006.

(a) Active Duty Drug and Alcohol Crime Trends

The Army had 69,686 known drug offenses from FY2006-11, which were committed by 36,311 unique Soldiers. Figure III-14 depicts active duty drug and alcohol trends per 100,000 Soldiers for this period. These trends reflect a decrease in drug and alcohol reporting across the 5-year period with an uptick in drug crimes from FY2010-11. This increase in the last year can largely be attributed to a 15% increase in drug use and a 33% increase in drug possession offenses (based on law enforcement investigations). At the same time alcohol-related crimes (DUI and drunk and disorderly) declined by 11%. Specifically, the offender rate for DUIs decreased by 10%, while the offense rate decreased by 8% in this period. Likewise, the offender rate for Drunk and Disorderly decreased 15% while the offense rate decreased 16% for the same period.

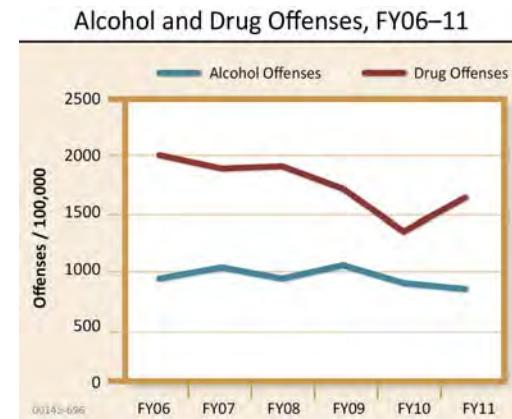


Figure III-14: AD Alcohol and Drug Offenses per Capita, FY06-11

VIGNETTE – FAILED SURVEILLANCE AND HIGH RISK BEHAVIOR

A senior Field Grade Officer became the subject of a founded Wrongful Use of a Controlled Substance investigation when she ingested a Fentanyl lollipop (pain killer) in 2011. The officer discovered the Fentanyl while inventorying medical equipment from theater; she was reported to authorities by Soldiers at the scene. She received a General Officer Letter of Reprimand for this offense.

While serving as a service provider in 2000 (MAJ), she used another provider's log-in credentials, prescribed and transmitted several prescriptions for herself, including Ambien (a controlled substance). A review of the DA Form 4833 indicated that her commander took administrative action (e.g., letter of reprimand) in response to this criminal conduct.

Despite indicators of potential drug abuse in 2000 and 2011, this officer has not been administered a urinalysis since 2003.

Drug Offense Composition

The table at figure III-15 highlights active duty drug crimes by drug crime sub-categories from FY2006-11. Army data indicate a general decline in drug offenses from FY2006-10 followed by an increase in the rate of drug offenders (13%) and offenses (21%) per 100,000 Soldiers in FY2011. Despite the increase in FY2011, drug crimes declined by 19% (per 100,000 Soldiers) from FY2006-11. This equates to a 4% average decline in drug offenses each year since FY2006. There were a total of 69,686

drug crimes from FY2006-11, comprised of the following drug offenses: 72% (50,111) drug use, 22% (15,271) possession and 4% (3,076) distribution. The remaining 5% of drug offenses were for drug introduction, smuggling and growth / manufacture. These crimes were committed by 36,311 Soldiers, which equated to, on average, 2 offenses per offender, again highlighting the need to focus on the repeat offender population.

Drug Crime Categories	FY06	FY07	FY08	FY09	FY10	FY11	FY06-11 Total
Use	8,894	8,427	9,324	8,738	6,840	7,888	50,111
Possession	2,893	2,724	2,525	2,405	2,028	2,696	15,271
Distribution	574	509	515	617	431	430	3,076
Introduction	144	139	135	178	128	187	911
Smuggling	55	46	29	39	25	37	231
Grow/Manufacture	10	9	5	8	8	20	60
Other	2	3	7	3	4	7	26
Total	12,572	11,857	12,540	11,988	9,464	11,265	69,686

Figure III-15: Drug Crime Composition, FY06-11

Urinalysis testing remained the primary means for detecting drug use from FY2006-11. Drug testing accounted for an average of 76% (38,163 of 50,111) of all drug use detected each year. Detection for remaining drug use was predominantly executed by law enforcement, which increased detection from an average of 22.4% from FY2006-10 to 32% in FY2011. This increase in law enforcement surveillance, presumably based on new policy in FY2011 that increased CID drug suppression team (DST) Manning, accounted for 75% of the total increase in drug use from FY2010-11. It is likely that this new policy also accounted for subtle increases in the reporting of other drug crimes (i.e., possession, introduction and growth / manufacture). The increase in DST Manning may prove to be the best tool for surveillance of other drug crimes, most notably detection of synthetic drug use, which often evades urinalysis detection.

VIGNETTE—DRUG ABUSE AND SUICIDE

In October 2010, a PFC informed his behavioral healthcare provider that he was depressed and had recent thoughts of suicide. He informed his provider that he abused cocaine, ecstasy, marijuana and Spice. He also stated that he intentionally burned himself recently while drunk. He declined a referral to ASAP. In addition to relationship problems with his girlfriend, the PFC was apprehended in early December 2010 for being drunk on duty (.09 BAC at 1030). He committed suicide four days later by entering his privately owned vehicle, dousing himself with gasoline and setting himself on fire.

Since joining the Army in July 2009, the PFC underwent urinalyses in January and February 2010 (both negative).

Drug and Alcohol Offenses as a Distribution of Grade / Rank

Consistent with all drug and alcohol statistics dating back decades, junior Soldiers E1-E4 commit the vast majority of all drug and alcohol crimes. Junior Soldiers tested positive for drugs at average rates (per 100,000 Soldiers tested) of 3.21% for E1, 2.23% for E2, 1.6% for E3 and 1% for E4 from FY2006-11. These rates declined dramatically for each successive rank across each rank category of NCO, warrant officer and officer. For example, average positive rates for NCOs were 0.31% for E5, 0.12% for E6...0.02% for E9; and for officers were 0.05% for O1, 0.04% for O2...0.01% for O6. Alcohol offenses closely parallel these findings with a distribution of offenses per 100,000 Soldiers of 3,485 for E1, 2,334

for E2, 1,680 for E3 and 1,378 for E4. Although E5s committed 868 alcohol offenses, WO1s committed 380 and O1s committed 483 per 100,000, the distribution quickly tapers off for each successive rank.

(b) ARNG and USAR Drug and Alcohol Crime Trends

The chart at figure III-16 provides a composite of drug testing results across the Army (as a percentage of positive drug samples per total samples tested) for AD, ARNG and USAR Soldiers from FY2006-11. Drug testing data alone, however, provides only a partial picture of total criminal drug offenses. Based on drug testing data, the ARNG has consistently led all COMPOs from FY2006-11, with the USAR surpassing AD in FY2009. Although drug testing data indicates a downward trend for all COMPOs in FY2011, total AD criminal drug offenses (based on drug testing and law enforcement activity) actually increased in FY2011. Without data from civilian law enforcement documenting other criminal drug offenses for ARNG and USAR (and to a lesser extent, AD) Soldiers, total drug offense comparisons between COMPOs are difficult to make.

The spike in ARNG and USAR drug offense reporting between FY2008 and FY2010 is likely due to revised policy (AR 600-85, The Army Substance Abuse Program) in FY2009 which mandated a change in RC drug testing from 100% annually to either 10% monthly or 25% quarterly. Again, this increase probably indicates an increase in surveillance and reporting rather than actual crime.

Similarly, gaps in civilian law enforcement reporting of alcohol-related offenses prevent any meaningful analyses for the RC. Less frequent unit contact in these populations reduces command surveillance of both drug and alcohol crimes. Nevertheless, a literature review of alcohol offenses among ARNG and USAR populations indicate that alcohol trends among the RC are similar to those in the AD population. A survey among 6,500 redeployed Soldiers from all COMPOs indicated similar trends of alcohol misuse (27% of survey respondents) but a 44% greater probability of drinking and driving among RC Soldiers along with 56% lower odds for enrollment into alcohol treatment.²⁶⁶



"There are many programs available to build the spectrum of wellness -- physical, emotional, social, family and spiritual...For all the progress that has been made, I remain concerned that a lack of direct and ongoing contact and interaction between Soldiers and leaders has taken a toll."²⁶⁷

– CSM Michael Schultz
Command Sergeant Major of the Army Reserve
2011

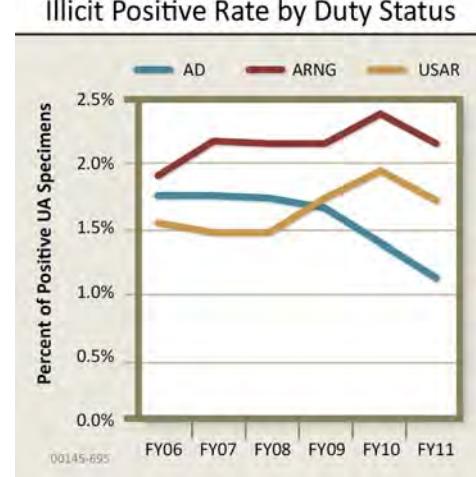


Figure III-16: Illicit Positive Rate by Duty Status, FY06-11

LEARNING POINTS

- ❖ The Army had 69,686 known drug offenses from FY2006-11, which were committed by 36,311 unique Soldiers. Despite the increase in FY2011, drug crimes declined by 19% (per 100,000 Soldiers) from FY2006-11.
- ❖ At the same time alcohol-related crimes (DUI and drunk and disorderly) declined by 11%. Specifically, the offender rate for DUIs decreased by 10%, while the offense rate decreased by 8% in this period.
- ❖ Consistent with all drug and alcohol statistics dating back decades, junior Soldiers E1-E4 commit the vast majority of all drug and alcohol crimes.
- ❖ Based on drug testing data, ARNG Soldiers have consistently led AD Soldiers in illicit positive UAs from FY2006-11, with USAR Soldiers surpassing AD Soldiers from FY2009-11. Much of the increase in positive UAs among the RC is likely due in part to a change in drug testing policy which increased testing rates.
- ❖ The increase in drug suppression team manning may prove to be the best tool for surveillance of other drug crimes, most notably detection of synthetic drug use, which often evades urinalysis detection.

(4) Gaps in Drug Surveillance, Detection and Response Systems

The total number of drug crimes reported in the Army from FY2006-11 is significantly less than the number of actual crimes committed due to a number of known gaps in drug surveillance, detection and response systems. This is arguably true of other DoD and national drug surveillance and reporting systems; in fact, drug testing within DoD provides impactful surveillance not provided across many national institutions. The Army's gaps in drug surveillance and reporting include under-testing of the Army population, a potential shift in illicit use of street drugs to pharmaceutical drugs (tested on a rotational basis), an increase in clearance rates based on slow implementation of testing policy, failure to refer drug offenses to law enforcement, and a failure to separate multiple drug offenders in accordance with policy. With the exception of the testing policy gap (which is currently being addressed through new policy) the Army has made improvements in the remaining areas. As mentioned earlier, improvement in drug reporting will likely reflect an increase in reported rather than actual crime with little or no expected change in the overall downward trend in drug crime. On the contrary, increased drug surveillance and reporting is expected to reduce *actual* crimes following a corresponding spike in *reported* crimes.

LEARNING POINTS

- ❖ The Army's gaps in drug surveillance and reporting include under-testing of the Army population, a potential shift in illicit use of street drugs to pharmaceutical drugs (tested on a rotational basis), an increase in clearance rates based on slow implementation of testing policy, failure to refer drug offenses to law enforcement, and a failure to separate multiple drug offenders in accordance with policy.

(a) Unit Drug Testing

The most obvious gap in drug surveillance, detection and response is due to the large population of untested Soldiers from FY2006-11. Figure III-17 depicts the untested AD population in each year with an average of 106,630 Soldiers who did not undergo urinalysis testing despite an average of 1.38 million samples tested annually from FY2006-11. The untested population has trended downward by ~35% since FY2006; particularly noteworthy was the reduction of the untested population (by 33,440 Soldiers) from a high of 122,750 in FY2008 to a low of 89,310 in FY2011. Using the weighted average positive UA rate of 1.41% for E1-E4, this would likely equate to ~ 1,500 drug offenders undetected in each year and 777 offenders (based on FY2011's actual rate) in FY2011. (This number would be lower if the calculation incorporated all grades / rates.) This gap in untested Soldiers mainly stems from a gap in policy that requires 100% testing of unit end strength (ultimately targeting 100% Army end strength) rather than testing 100% of unique Soldiers within the population. A revision of this policy is currently in draft to mandate 100% testing of the unique Soldier population and is expected to be implemented in FY2013. In the meantime, commanders continue to reduce this gap by increasing urinalysis testing by an average of 58,726 samples annually, with an actual increase of 111,630 samples in FY2011 alone.

The seasonality of reported drug crimes, evident in the spike in the second quarter of each year from FY2006-11 supports the growing body of evidence that a certain percentage of drug crimes remain undetected. This quarterly increase (as illustrated at figure III-18, blue bars) is the result of a doubling of testing rates in January (orange line) following the holiday period. In other words, leaders could reasonably expect the same “cause and effect” relationship between surveillance and detection independent of timing (e.g., increase in testing following the 4th of July would have a similar effect). Again, as leaders close the gaps in surveillance and detection, they can expect a generalized increase from a “January effect” in drug reporting on a quarterly or annualized basis.

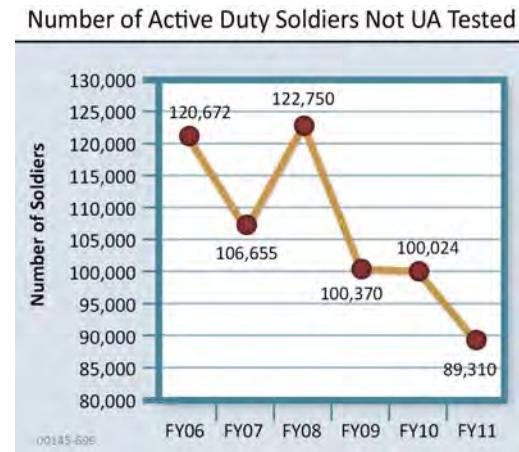


Figure III-17: Number of Active Duty Soldiers Missing Annual Urinalysis Testing

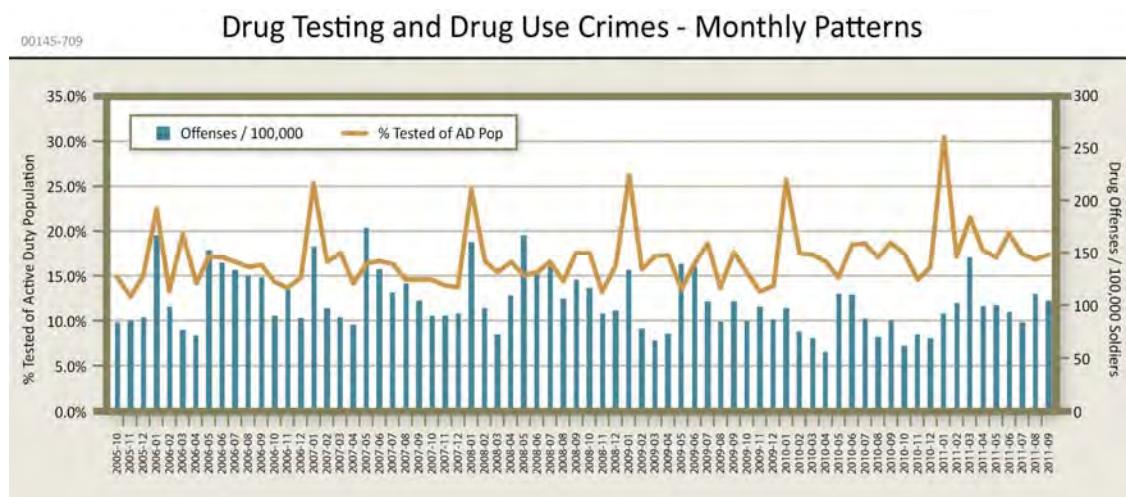


Figure III-18: Drug Testing and Drug Use Crimes – Monthly Patterns, FY06-11

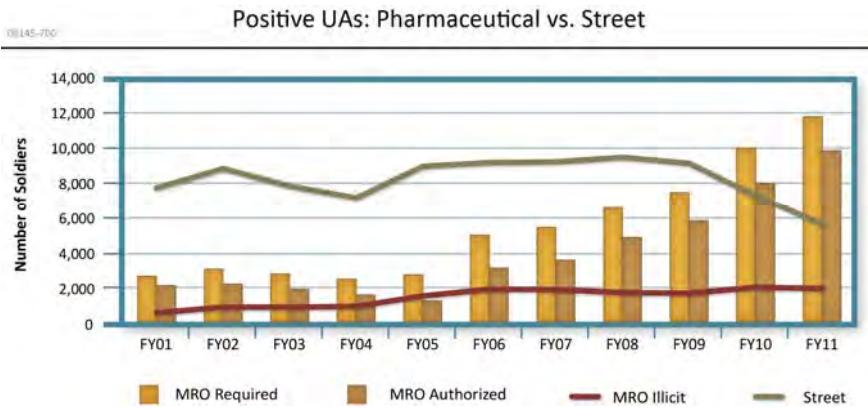
Similar to the seasonality in drug testing and reporting, increased emphasis in conducting random unit sweeps (100% testing of unique individuals) has proven to be a more effective technique for screening Soldiers than randomly testing a percentage of the unit population on a monthly basis. Identification of Soldier drug abusers was more successful during unit sweeps (at 0.8% of samples tested) compared to random unit testing (at 0.6% of samples tested). The fact that unit sweeps are 33% more effective than random testing is further supported by data from FY2001-11 that revealed unit sweeps were more effective in 10 out of 11 years. Based on an average of 1,376,000 specimens tested annually, the unit sweep approach would identify an additional 2,752 illicit drug users. And given the nature of drug abuse, this technique would only require intermittent use to be effective. Also using random unit sweeps combined with random monthly testing will achieve an optimum balance between surveillance effects and resource conservation. Either way, testing must be conducted randomly.

LEARNING POINTS

- ➊ From FY2006-11, an average population of 106,630 AD Soldiers was not tested despite an average of 1.38 million samples tested annually. However, the untested population has trended downward by ~35% since FY2006.
- ➋ Commanders continue to reduce this gap by increasing urinalysis testing by an average of 58,726 samples annually, with an actual increase of 111,630 samples in FY2011 alone.
- ➌ Conducting random unit sweeps (100% testing of unique individuals) has proven to be a more effective technique for screening Soldiers than random testing on a monthly basis. Using random unit sweeps combined with random monthly testing will achieve an optimum balance between surveillance effects and resource conservation.
- ➍ The increase in 2^d quarter drug offenses is likely due to an emphasis in post-holiday testing rather than seasonality associated with illicit drug use.

(b) MRO Review Process

Perhaps the most alarming surveillance gap involves the slow implementation of prescription testing policy. The Medical Review Officer process validates all positive urinalysis samples containing prescription drugs to determine if each detected drug matches any authorized prescription, regardless of the date of



issuance. For example, if a Soldier tested positive for opiates in FY2011 but had received a prescription for codeine in FY2008, the drug use would be cleared as authorized use. This is because many prescriptions are labeled "use as needed" without a hard expiration date. As the number of issued prescriptions has dramatically increased across the Force, the corresponding use of this medication has increased the requirement for MRO reviews and, likewise, the probability that the drug use will be authorized. This has increasingly reduced the impact of surveillance in detecting illicit use of prescription medication from FY2001-11. The chart at figure III-19 illustrates this loss in drug

surveillance. As prescriptions have increased year over year, the numbers of initial positive UAs requiring an MRO review (orange bars) and the numbers of MRO UA samples deemed “authorized” (brown bars) have increased in tandem.

As prescriptions with no specific expiration date pile up, increasing surveillance of potential illicit use of medication will not likely increase detection. This lack of expiration date is of particular concern as Soldiers are potentially provided more prescriptions (to assist with various medical conditions) that may have a deleterious health effect when taken together. In other words, because Soldiers are getting prescriptions for medications that may be safe when taken alone, they may not understand the danger of reaching for a medication previously prescribed that may have adverse effects when used in combination with newly prescribed medication. Without an expiration date, medical professionals may not fully understand the list of medications that Soldiers are currently “using” beyond their original prescribed intent. The fact that there were 49,800 Soldiers in FY2011 alone that were issued three or more unique psychotropic and / or controlled substance prescriptions (with a 15-day supply or more), lends credence to this concern.

The chart at figure III-20 provides a more specific example using FY2001-11 data for drug testing across several drug classes (amphetamines, oxys and opiates). As prescriptions for amphetamines and oxys increased from FY2001-11, authorized use rates approached 90%, meaning less than 10% of all drug use for these two classes were deemed illicit use. Most notable is the

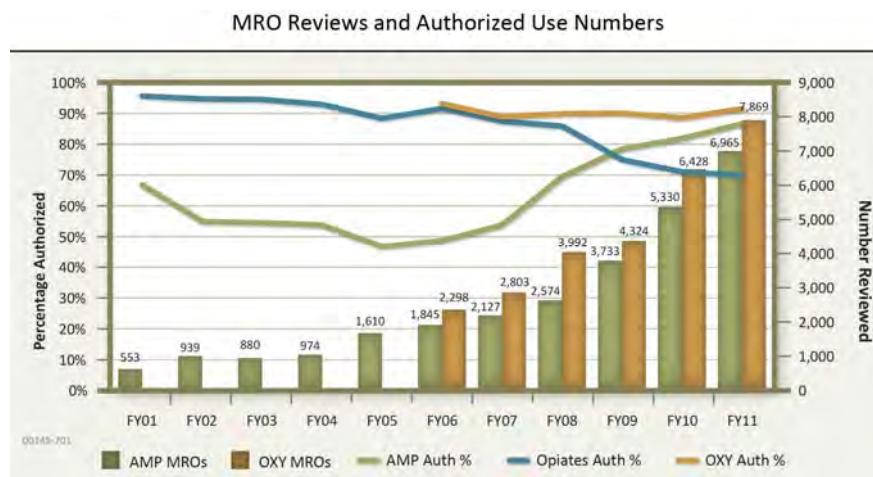


Figure III-20: FY01-11 MRO Reviews and Authorized Use Numbers

increase in the authorization rate for amphetamines (green line). Authorization rates for amphetamines increased dramatically from a low in FY2005 of ~40% (or 60% illicit use) to almost 90% authorized use (or 10% illicit use) by FY2011. Equally notable was the trend for oxys (orange line). When Oxy testing was introduced in FY2006, prescription levels immediately impacted MRO authorizations, which have remained at ~90% through FY2011. While opiate use (blue line) represents only a small percentage of overall drug reviewable numbers at ~8%, the overall authorized rate has steadily declined since FY2006. This decline is likely the result of increased heroin use by ~150% among those tested from FY2006-11.

Additionally, the gap in the MRO process may be masking a transition of drug abuse patterns from street drugs to prescription medication (e.g., from heroin to prescription opiates or from illegal amphetamines to Adderall) per figure III-19. While the number of Soldiers with an initial positive UA sample (prescription and street drugs) has increased, detection of street drugs is on the decline (green line). Although the number of prescription samples deemed “illicit use” through MRO review (red line) shows only a slight increase, known gaps in testing are masking the true magnitude of this increase. This means that the gap between illicit use of street drugs and prescription medication is even narrower than the gap formed by the red and green lines at figure III-19, which likely indicates a switch in drug use from street drugs to prescription drugs. In other words, illicit use of street drugs (easily detected by UA testing) has declined by a known quantity of 23% from FY2010-11. At the same time, positive UAs for

prescription medication (often eluding UA detection) have increased by a known quantity of 18% but, due to gaps in testing, the total amount of illicit use of prescription medication remains unknown. For example, if the gaps in testing were closed, illicit use of prescription medication may account for approximately 1,600 Soldiers who were undetected in FY2011. This estimate is consistent with the loss in illicit use of street drugs by 1,684 Soldiers from FY2010-11. When this estimate is added to the number (1,954) of detected illicit prescription users in FY2011, it would mean that there were potentially more than 3,500 Soldiers who illicitly used prescription medication in the same period.⁹

This potential switch is arguably due to a variety of factors including availability, cost and low detection rates associated with prescription medication use. As prescriptions have continued to proliferate, with controlled and psychotropic prescriptions increasing 11% to 135,528 prescriptions (>15 days) from FY2010-11, more Soldiers will have a greater number of previously recorded prescriptions that will result in an MRO authorization, potentially neutralizing any surveillance of illicit use across a broad array of medications. This is consistent with a variety of metrics that indicate a widening of this gap in the MRO process. Of the 24,424 positive UAs in FY2011, 67% (16,443) were for prescription medication with MROs clearing 85% (13,990) of the samples tested. Moreover, MROs cleared 1,085 UA samples from FY2010-11 that involved prescriptions that were six months or older as of the sample collection date. Regardless of whether use involves a prescription or not, however, the potential consequences are serious. Although illicit use of pharmaceuticals composed 21% (1,563 of 7,585) of all unique Soldiers involved in illegal drug use in FY2011, the potential outcomes are often more serious. For example, of the 197 undetermined and accidental deaths that involved drugs from FY2009-11, 142 involved prescription medication.

VIGNETTE— ILLICIT DRUG USE

A 23-year-old PVT reported to his new assignment in June 2011 while the unit was on block leave. He was administered a urinalysis on 18 July 2011. Four days later, he was found dead in his barracks room after he did not report for duty. He tested positive for Morphine, Hydromorphone, Fentanyl (all Opiates) and Cannabinoids.

The MRO process was corrected through a new policy issued by MEDCOM in February 2011 that limits prescription use to six months from date of issuance and provides only a 30-day supply at a time, with a maximum of five refills. Although the policy has been issued Army-wide, it has not been fully implemented, and therefore has not reduced the prescription expiration gap. Currently, the MRO review process has not incorporated the policy to determine unauthorized prescription medication use for positive samples exceeding the six month prescription window. MRO implementation is awaiting Army-wide notification to ensure all Army personnel, particularly unit personnel, understand the ramifications of this policy, which will consider use of medication beyond its six-month prescription window as illicit use. Development and distribution of an Army STRATCOM mandating education and training is still required to fully implement this policy.

The Army's MRO process is postured for full implementation of this new policy. The Army Center for Substance Abuse Program's (ACSAP) new automated MRO system is fully fielded. This system allows MROs to input review results directly into an Army-wide database that can be viewed at all levels of the program. This continues to streamline the review process even as the number of UAs requiring MRO reviews has increased by 453% (2,979 to 16,478) from FY2001-11. Meanwhile, the percent of reviews

⁹ This estimate is based on assumptions regarding known testing rates: 100% tested population; increasing amphetamines, opiates, and oxy sample testing from ~20% to 100%; and the number of prescriptions that were beyond the six-month expiration window.

FY	MRO Evaluations Required	MRO Evaluations Completed	Percent Completed
FY01	2,979	1,862	62.5%
FY02	3,546	2,412	68.0%
FY03	3,188	2,314	72.6%
FY04	2,948	2,173	73.7%
FY05	3,569	3,043	85.3%
FY06	5,971	5,552	93.0%
FY07	6,402	6,142	95.9%
FY08	7,832	7,607	97.1%
FY09	9,400	9,163	97.5%
FY10	13,202	13,003	98.5%
FY11	16,478	16,134	97.9%

Figure III-21: MRO Completion Rates for AD Soldiers

undetected from FY2001-11 and 43 Soldiers in FY2011 alone (assumes FY2011 post MRO illicit rate of 12.5%). While this represents an extremely small margin of error, it could have a greater impact as the number of MRO evaluations required increase year over year.

completed has improved 57% (62.5% to 97.9%) from FY2001-11. In fact the Army has sustained a completion rate over 97% since FY2008, with the FY2011 completion rate of 97.9% expected to improve as fiscal year evaluations are closed out. Although the remaining gap in completion rates is small—with the smallest impact of any surveillance gap identified—it represents 6,110 incomplete evaluations from FY2001-11, which could have potentially accounted for 764 illicit drug users going

VIGNETTE— IMPACT OF PTSD, ALCOHOL AND ILLICIT PRESCRIPTION DRUGS

A recent MSNBC article titled An Epidemic: Pharmacy Robberies Sweeping US (June 2011) highlights some of the national issues involving pain medication. It featured a growing trend in collateral crimes associated with America's growing dependency on pain medication. The article reported an 86% increase in armed robberies involving pharmacies, which has increased from 389 in 2006 to 686 in 2010. These robberies accounted for an increase in the number of pills stolen annually from 706,000 to 1.3 million. It highlighted the fact that illicit use of prescription painkillers is second only to marijuana use with a reported 7 million people abusing pain killers in May 2011 alone. Abuse of painkillers on such a grand scale fueled a 200% increase in the number of emergency room interventions from 144,644 in 2004 to 305,885 by 2008.²⁶⁸ This article indicates that abuse of prescription medication is a national issue with corresponding implications for Army drug surveillance, detection and response. Although the Army has not seen this level of collateral crimes associated with drugs, the following vignette highlights the potential reality of its impact.

A 37-year-old sergeant assigned to a Warrior Transition Unit pleaded guilty to two counts of third-degree robbery after robbing two pharmacies and stealing approximately 950 morphine and OxyContin tablets worth \$1161.00. Police identified him by the unit sweatshirt he was wearing during one of the robberies. The sergeant stated the stolen pharmaceuticals were for his personal use.

LEARNING POINTS

- ➊ Drug data indicate a transition of drug abuse patterns from street drugs to prescription medication (e.g., from heroin to prescription opiates or from illegal amphetamines to Adderall).

- ➊ The MRO process was corrected through a new policy issued by MEDCOM in February 2011 that limits prescription use to six months from date of issuance and provides only a 30-day supply at a time, with a maximum of five refills.
- ➋ MRO implementation is awaiting Army-wide notification to ensure all Army personnel, particularly unit personnel, understand the ramifications of this policy, which will consider use of medication beyond its six-month prescription window as illicit use.
- ➌ While prescription medication composed 21% of all positive UAs in FY2011, they have proven to be significantly more dangerous than street drugs. Of the 197 drug-related (undetermined and accidental) deaths from FY2009-11, 142 involved prescription medication.

(c) Drug Surveillance and Testing Protocols

The former Chairman of the Joint Chiefs of Staff recommended numerous changes in drug testing policy in a memorandum titled *A Systems Approach to Drug Demand Reduction in the Force, 1 November 2010*.²⁶⁹ This memorandum to the Services conveyed a strong message that drug testing procedures launched in the 1980s have made only minor modifications that have not kept pace with today's Force. As the Chairman warned, "We are...facing a growing series of problems that risk making our drug testing paradigms ineffective." The message suggested that policy for drug testing must compensate for changes in Force composition (based on competing demands to fill ranks for deployments) and remove "drug using troops." It also recommended increased testing to include the most commonly abused prescription drugs. Perhaps its most powerful recommendation was to increase funding to counter "growing concerns among commanders that drug use is a problem within the ranks, DoD drug testing programs have remained at a budget flat line for the past several years and are facing an estimated \$11 million short fall." The Chairman's recommendations are powerful and consistent with the findings of this subsection.



"Rising rates of legal narcotics prescriptions without a seamless capability to quickly verify the prescription means that these actually cloak the real extent of the problem."

— ADM Michael Mullen
Former Chairman, Joint Chiefs of Staff
1 November 2010

The types of drugs tested and testing rates for a variety of drugs represent yet another gap in drug surveillance. Drugs commonly tested include marijuana, cocaine, heroin, amphetamines, opiates, PCP and oxys (opiate derivatives). However, codeine, morphine, PCP and oxys are only included on 20% of the drug testing panels. This means that the random samples from Soldiers who illicitly use these drugs have only a 1 in 5 chance of being detected. The Army, moreover, does not test for other potential drugs of abuse such as hydrocodones (e.g., Vicodin) or benzodiazepines (e.g., Valium) which are generally available to Soldiers whether prescribed or unprescribed. These drugs, in total, accounted for 389,489 issued prescriptions in FY2011 alone, indicating the wide availability of drugs not tested.

Additionally, Army leaders are increasingly concerned regarding emerging synthetic drugs including synthetic cannabinoids (generally referred to as Spice or K2) and amphetamine-like compounds known as "bath salts." Even more alarming is the fact that they have proven to be more dangerous than organic marijuana and other controlled substances. Spice was designated as a Schedule I narcotic (illegal substance) in March 2011. Although the Army implemented policy which considers its use as a

felony crime under the UCMJ, testing is only done upon request and only when in conjunction with a law enforcement investigation. From March to September 2011, there were 342 cases that involved requests for testing to determine potential use of Spice. Of the 342 investigative cases referred for testing, 73% (264 offenders) were titled for illicit use as a result of a positive finding.

According to a New York Times article, the DEA took emergency action in October of 2011 to ban synthetic stimulants that are used to make synthetic drugs marketed and sold under the moniker “bath salts”. This ban places bath salts under the DEA’s most restrictive category pending a potential drug ban. The Army has not yet banned the use of bath salts per se, it has a blanket ban on the use of controlled substance analogues (designer drugs) “...for the purpose of inducing excitement, intoxication, or stupefaction of the central nervous system.”²⁷⁰ As a result, use would also be a violation under the UCMJ. Policy banning of synthetics is a critical step in Army drug surveillance programs because of the highly addictive and toxic nature of these compounds of synthetics. “Despite their innocuous sounding street names, doctors say these drugs are unusually dangerous. Users can experience severe, long-lasting paranoia...and bouts of extreme violence, sometimes self-inflicted.”²⁷¹

Synthetic drugs often elude traditional surveillance and detection methods; testing is not as reliable because of the rapid adaptation of synthetic compounds. However, as policy becomes more responsive and as science improves, new screening techniques are expected to become more effective. Until then, given the challenges in screening for synthetics and the current limits in testing for prescription medication, command and law enforcement collaboration remains the most effective means for improving illicit drug use surveillance, detection and response systems.

VIGNETTE—TRANSMITTABLE CRIME & DEATH

In April 2011, a SGT was involved in a high speed chase with civilian police on an interstate highway. After police forced his vehicle into a jersey barrier, the SGT shot and killed his wife who was in the passenger seat. He then committed suicide by shooting himself in the head. As local police searched the SGT’s residence, they located the body of his six-year-old son.

Toxicology results revealed the SGT and his wife were under the influence of bath salts. According to his medical records, the SGT was severely paranoid and manic but was prescribed medications to mitigate these conditions. Medical experts stated that the SGT’s use of bath salts would have most likely severely magnified his paranoia and mania.

During the course of this death investigation, a PFC in the same unit confessed that she told the SGT how he could purchase bath salts and was present when he consumed the drug. In an earlier and separate investigation (January 2011) that stemmed from a commander’s health & welfare inspection, this PFC admitted to manufacturing a mixture of bath salts and spice and distributing the substance to another Soldier. In another investigation (May 2011), this PFC admitted to using bath salts and possessing drug paraphernalia; both were found in her clothing upon admission to ASAP treatment. The PFC was separated under Chapter 14 (Misconduct) and received an Under Honorable Conditions (General) discharge.

Finally, offenses associated with the possession of drug paraphernalia (including synthetic drugs in some cases) present a final gap in drug surveillance. Possession of drug paraphernalia is a felony but it is currently reported as a subcategory under Failure to Obey an Order or Regulation, when in fact, it should be correctly characterized as a drug crime. This gap adds a significant population that should be included in the aggregate of under reported offenses. For example, there were 1,561 offenses for possession of drug paraphernalia in FY2011 (up 155% from FY2010). Moreover, drug paraphernalia

offenses rose by 565% from FY2006-11. If these offenses had been correctly categorized as drug offenses, they would have driven the total offense counts up by 14% in FY2011 alone. The Army is moving forward in closing this gap with policy already in draft to correctly classify this offense as a drug crime to ensure accurate reporting.

(d) Law Enforcement Referrals

A lack of referrals for illicit drug use to law enforcement continues to adversely affect the Army's drug surveillance, detection and response. Although the gap in referrals from commanders to law enforcement widened between FY2006 and FY2009 (from 3,413 unREFERRED cases to 4,045), this trend reversed course in FY2010 with the reduction of unREFERRED cases falling to 2,274 in FY2011 (See figure III-22, red line). Increasing law enforcement referrals, moreover, is critical to reducing other gaps across drug surveillance, detection and response systems. In recognition of its importance, the Army has drafted policy that will require ASAP to simultaneously refer all positive UAs to both commanders and law enforcement. This simple but impactful revision to policy will close current referral / investigative gaps as well as increase follow-on drug investigative, surveillance and detection efforts.

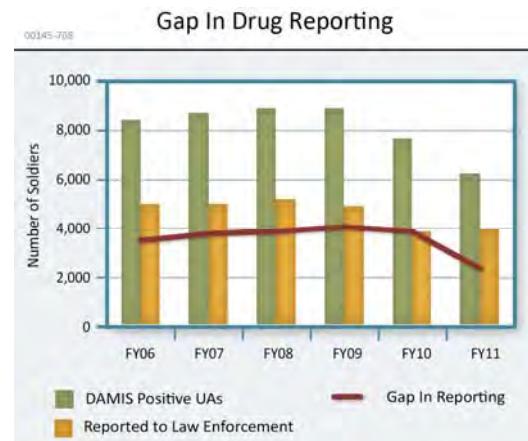


Figure III-22: Gap in Drug Reporting

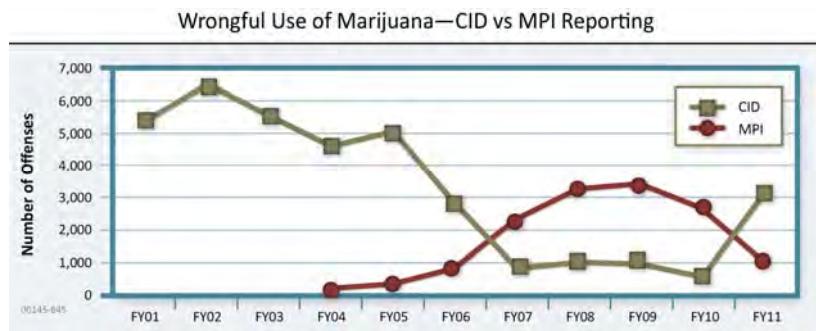


Figure III-23: Drug Trends – Wrongful Use of Marijuana, CID vs. MPI Reporting

reach its full effect until mid-FY2012. The chart at figure III-23 illustrates the loss in marijuana surveillance and subsequent investigations from FY2005-10, with cases at almost half their historic range. This gap in investigations may account for 1,000-1,500 illicit marijuana users going undetected or not investigated from FY2005-10.

CID transferred the mission to MPI in FY2006 while MPI requirements were surging in support of OIF, which left the mission undermanned at the largest installations. Following a review of marijuana investigations and MPI's increased workload outlined in the *Red Book*, CID reassumed the mission in mid-FY2010. This transition provides a valuable lesson in planning, implementation and follow-up. Without closely monitoring the effects of the policy change, the Army lost program efficacy which remained uncorrected for a number of years. Since remissioning, CID investigations of marijuana have increased by 50%.

Another gap affecting law enforcement investigations was created by the transition of positive UA marijuana investigations from CID to Military Police Investigators (MPI) in FY2006. This gap was corrected in FY2010 and has demonstrated significant improvement in surveillance, detection and response to marijuana use, but may not

LEARNING POINTS

- ★ Drugs commonly tested include marijuana, cocaine, heroin, amphetamines, opiates, PCP and oxys (opiate derivatives). However, codeine, morphine, PCP and oxys are only included on 20% of the drug testing panels.
- ★ The Army implemented policy which considers its use of Spice as a felony crime under the UCMJ.
- ★ Possession of drug paraphernalia is a felony but it is currently reported as a subcategory under Failure to Obey an Order or Regulation but should be correctly characterized as a drug crime.
- ★ From FY2009-11, the Army has reduced unferred positive drug samples to law enforcement from 4,045 to 2,274.
- ★ Since assuming marijuana investigations in FY2010, CID has increased illicit use reporting by 50%.

(e) Repeat Drug Offenders FY2006-11

Multiple (defined as two times) and serial (defined as three or more times) drug offenders are briefly highlighted here within the context of drug offenses but will be reviewed in depth under the Multiple Felony Offender subsection of this chapter. The table at figure III-24 provides the number of unique active duty and non-mobilized Reserve Component Soldiers who tested positive for illicit use of drugs from FY2006-11. The total number of unique AD Soldiers who tested positive for illicit drug use was substantial, with 43,082 illicit drug users from among 1,370,068 Soldiers tested during this period. The vast majority of these Soldiers (or 64%) were one-time offenders. What is disconcerting, however, was the number of multiple and serial drug offenders who remained on AD from FY2006-11. There were, 8,159 (19%) multiple drug offenders and 7,292 (17%) serial offenders identified during this period. Given the gaps in surveillance, detection and response systems discussed previously, leaders can expect these numbers to be significantly higher.

Component / Status	Unique Soldiers Tested	Soldiers Positive for Illicit Use		One-Time Positives	Multiple (2-Time) Positives		Serial (3+) Positives		
		Positive	Percentage		Positive	Percentage			
Active Duty (includes ARNG and USAR)	1,370,068	43,082	3%	27,631	64%	8,159	19%	7,292	17%
Reserve Component	721,441	34,252	5%	24,330	71%	6,878	20%	3,044	9%
Non-Mobilized ARNG	453,590	24,182	5%	16,758	69%	5,009	21%	2,415	10%
Non-Mobilized USAR	267,851	10,070	4%	7,572	75%	1,869	19%	629	6%
Total - AD and RC	2,091,509	77,334	4%	51,961	67%	15,037	19%	10,336	13%

Figure III-24: Active Duty and Reserve Component Drug Testing Data, FY06-11

The population of multiple and serial drug offenders within the RC (i.e., ARNG and USAR Soldiers) conveys a similar story. The combined total of unique non-mobilized RC Soldiers who tested positive for illicit use was 34,252 from among 721,441 unique Soldiers tested during this period. The majority (or 71%) of these Soldiers were one-time offenders, while 20% were multiple and 9% were serial offenders. Again, due to similar gaps in RC drug surveillance, detection and response, these numbers are likely higher.

Leaders must intuitively question the fitness, discipline and professionalism of any Soldier who commits multiple or serial drug offenses. The intent of Army policy (AR 600-85) remains consistent with Army values, which directs commanders to initiate separation for a first-time drug offense (waivable) and to process separation for a second-time drug offense (second time illicit drug use requires General

Officer approval to retain). Any compromise in adjudicating and separating multiple and serial drug offenders represents a compromise in the composition of the Force, its discipline and its obligation to the welfare and safety of others. Drug offenses are among the most intractable crimes as noted in the percentages of those who are repeat offenders. In fact, of those who commit first-time drug offenses, 36% will commit a second offense. But perhaps more telling is the probability that, among those who commit a second offense, 47% will go on to commit three or more drug offenses.

LEARNING POINTS

- ★ The AD had 27,631 first-time drug offenders, 8,159 multiple offenders and 7,292 serial offenders identified from FY2006-11.
- ★ The RC had 24,330 first-time offenders, 6,878 multiple offenders and 3,044 serial offenders identified from FY2006-11.
- ★ 36% of first-time drug offenders will commit a second drug offense; of those, 47% will go on to commit three or more drug offenses.

(f) Aggregate Drug Crime Estimates

An estimate of the total number of Soldiers who committed drug crimes but went undetected due to gaps in drug surveillance, detection and response systems was calculated for FY2011. There were potentially 8,368 unique Soldiers who went undetected, unreported and who were not investigated or adjudicated for their drug-related crimes. This number includes the estimate for illicit use of prescription medication (~3,500). This calculation illustrates the potential magnitude of drug crimes across the Army including illicit use, possession (drugs and paraphernalia), and distribution. Most notable among this population are sub-populations who evaded identification and adjudication for the following reasons: (1) 2,413 Soldiers who may have slipped through gaps in urinalysis testing;¹⁰ (2) 2,274 positive UAs not referred to law enforcement; (3) 1,553 who could have been detected through efficiencies in random unit sweep testing;¹¹ (4) 1,307 Soldiers apprehended for drug paraphernalia; and (5) 562 Soldiers whose prescription use exceeded the 6-months expiration; among others. This calculation is limited by a lack of fidelity between discrete populations that may double count some Soldiers who committed multiple offenses, by estimates of drug positive rates underpinning the equation, and by the fact that some Soldiers may have been detected and adjudicated but were not reflected in drug crime reporting. However, there were other potential illicit users who were not included in this estimate due to a lack of surveillance across known gaps (e.g., prescription drugs not tested such as benzodiazepines and hydrocodone, which accounted for 389,489 prescriptions in FY2011 alone). Again, because these gaps have existed for a number of years, this estimate does not indicate an increase in illicit drug use but rather an increase in the number of illicit users that go undetected.

LEARNING POINTS

- ★ Based on analysis of gaps in drug surveillance, it is estimated that potentially 8,368 unique Soldiers may have committed drug crimes in FY2011 but who went undetected, unreported and untreated.

¹⁰ Untested population multiplied by the discrete positive UA rate for each drug.

¹¹ Reflects a 0.2% increase in the efficiency of unit sweep testing over random percentage testing.

(5) Sex Crime Trends

Sex crimes can have an enduring impact on the victim, with the effects of the event often lasting years. Research in this area places military sexual trauma (MST) among the more serious physical and behavioral health conditions outlined in Chapter 2.¹² According to one study, “Military sexual trauma (MST) is reported by 20-40% of female veterans resulting in PTSD, depression, and sleep difficulty.”²⁷² Of those reporting MST, 66.4% suffered from chronic pain associated with abuse-related trauma, physical health and trouble sleeping. This is consistent with other research that found among women with PTSD, 31% screen positive for MST with associated comorbid depression, anxiety and eating disorder diagnoses.²⁷³ Any of these findings are associated with conditions that, above and beyond the trauma related to the sex crime, could presumably require long-term physical and behavioral healthcare. Nevertheless, they are indicative of the real impact of sex crime on victims, an impact that is at the heart of Army policy and program mitigation efforts.

Crime Category	FY06	FY07	FY08	FY09	FY10	FY11
Violent Sex Crimes	665	827	908	1,165	1,242	1,313
Rape	418	535	348	406	461	515
Aggravated Sexual Assault		1	273	420	412	414
Forcible Sodomy	220	267	261	316	342	349
Attempted Rape	27	24	20	20	22	29
Attempted Aggravated Sexual Assault			6	3	5	6
Other Sex Crimes	954	919	929	938	937	977
Total Sex Crimes	1,619	1,746	1,837	2,103	2,179	2,290

Figure III-25: Sex Crimes (Number of Offenses) Committed by AD Soldiers

Sex crimes in the AD Army have trended upward with a 28% increase in the offense rate and an increase 20% in offender rate from FY2006-11. This trend was fueled by a marked increase in violent sex crimes up ~97% and a subtle increase in other sex crimes up 2.4% from FY2006-11. The table at figure III-25 depicts sex crime for both violent sex offenses (e.g., rape, aggravated sexual assault, etc.) and other sex offenses (e.g., wrongful sexual contact, indecent acts, etc.). During this period there were a total of 11,774 sex offenses committed by 8,215 offenders, which was generally comprised of an increasing number of offenses in each year, ending in FY2011 with 2,290 sex offenses committed by 1,531 Soldiers.

LEARNING POINTS

- ★ Sex crimes in the AD Army have trended upward with a 28% increase in the offense rate and an increase of 20% in the offender rate from FY2006-11.
- ★ Females represent only 14% of the Force but composed 95% of all sex crime victims from FY2006-11.

¹² According to the Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma (MST) is defined as psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training.

(a) Violent Sex Crime Trends

The rate of violent sex crime, while seasonal, has increased year over year since FY2006. An analysis of data from FY2006-11 indicates that violent sex crime is growing at an average rate of 14.6% per annum or 79.4 sex offenses per 100,000 per year. And the rate of violent sex crime is accelerating. Additionally,

there has been a shift in the last three years which indicates an escalation of sex crimes (month over month) which was previously absent. The chart at figure III-26 illustrates this escalation by dividing data analysis between FY2006-08 (red area) and FY2009-11 (blue area) to illustrate the average number of sex offenses per month for each period. This bifurcation reveals that, unlike previous years, each sequential month (starting in October) demonstrates a consistent increase in sex crimes.

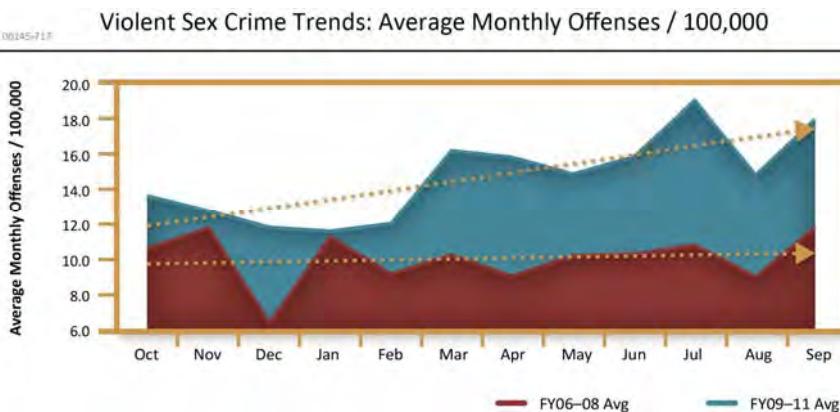


Figure III-26: Violent Sex Crime Trends: Average Monthly Offenses / 100,000

Rape, sexual assault and forcible sodomy were the most frequent violent sex crimes committed in the Army in the last year. In FY2011 alone, CID founded 515 rapes, 414 aggravated sexual assaults and 349 forcible sodomies. This equated to an 11.7%, 0.5% and 2.0% increase from FY2010 respectively. From FY2006-11, the Army had 2,683 rape offenses committed by 2,273 offenders. Over this period, the rate of offenses increased by 12% while the number of offenders per 100,000 decreased by 1.4%. Similar to overall violent sex trends, rape offenses increased by 13.8% from FY2010-11, with a corresponding 11.7% increase in the number of offenders (per 100,000).

The number of aggravated sexual assault offenses peaked in FY2009 and remained at FY2009 levels through FY2011. Over this period, an average of 373 offenders committed 415 offenses each year. Again, the discrepancy between offense and offender counts for both rape and aggravated sexual assault indicates that some offenders are committing multiple offenses.

Forcible sodomy (of a female or male) increased from FY2006-11, to a level of 349 offenses (a 44% increase from FY2006) committed by 280 offenders (a 36% increase since FY2006). Over the six year period, the Army totaled 1,755 forcible sodomy offenses committed by 1,485 offenders, again demonstrating the propensity of individual offenders to commit multiple offenses. The Army is currently monitoring same gender sex crime for a potential increase in forcible sodomy and other sex offenses related to the disassociation of homosexuality from the crime itself. It is reasonable to expect that aggressive acts occur which may result in a sex crime against same gender partners, but now victims may be more likely to report sexual offenses in the absence of the former Don't Ask, Don't Tell policy. There were no discernable trends regarding same gender sex crimes as of the publication of this report.

LEARNING POINTS

- ★ There were 8,215 Soldiers who committed sex offenses from FY2006-11 with 1,531 in FY2011.

- ★ From FY2006-11, the Army had 2,683 rape offenses committed by 2,273 offenders.
- ★ Violent sex crime in FY2011 clearly diverged from a seasonal pattern with an elevated trend upward, well above previous years.

(b) Other Sex Crimes Trends

A comparison of other sex crimes from FY2006-11 revealed that there were a total of 5,654 offenses comprised of a variety of lesser sex crimes (e.g., wrongful sexual contact, indecent acts upon a child, abusive sexual contact), committed by a total of 4,054 Soldiers. An examination of the per capita rates for these crimes over the six year period indicates a 7% decline in offense and 11.5% decline in offender rates. These crimes demonstrated similar but less pronounced seasonal characteristics following a flat trend line from FY2007-09.

(c) Seasonality of Sex Crime

An analysis of violent sex offenses revealed remarkably consistent seasonal variation from FY2006-10; it further highlighted a marked increase in these offenses in FY2011 in stark contrast to previous years. As illustrated in the chart at figure III-27, the seasonality of violent sex crime from FY2006-10 reflects a pronounced average decrease of 34% between November and

December followed by an equally pronounced increase of 39% between December and January. However, violent sex crime in FY2011 clearly diverged from this seasonality with an elevated trend upward, well above previous years. This is supported by the fact that there was no cyclic reduction in December, followed by an unprecedented rise in January as the FY2011 trend line (orange line) departed a fairly rigid formation set in previous years. This chilling trend suggests that the increase in offenses going forward will likely continue unless directly mitigated by other factors.

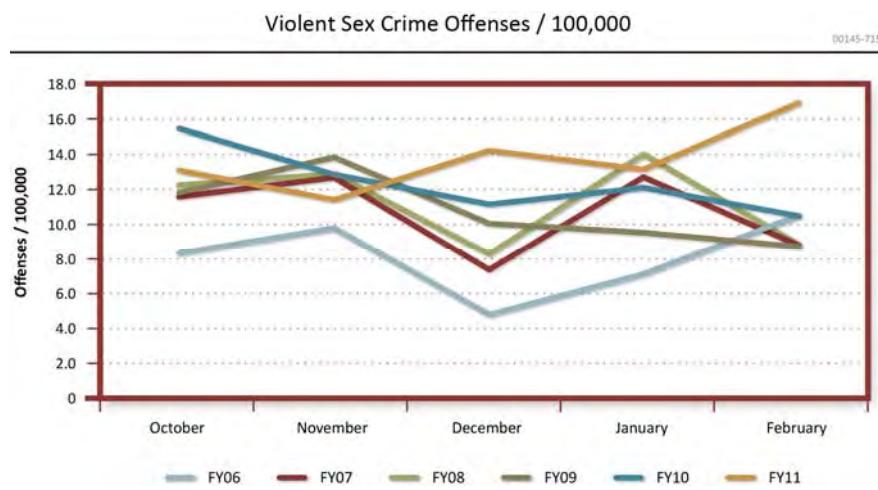


Figure III-27: Violent Sex Crimes, October-February Monthly Trends

Examining trend lines by individual quarter since the first quarter (Q1) of FY2006 demonstrates increasingly cyclical peaks during the fourth quarters of FY2008-11 (Figure III-28). The spike in violent sex crime during the fourth quarter each year may in part be a factor of the normal military transition cycle. Over a third of the Force transitions each summer (June - August) with the majority of Soldiers integrating into their new units during this period. During transition, young female Soldiers are more vulnerable to victimization until they are fully integrated into their chain of command and have developed a more established social network. This may be more problematic during unplanned transitions (last minute fills for deployment) and for low-density support Soldiers who may experience

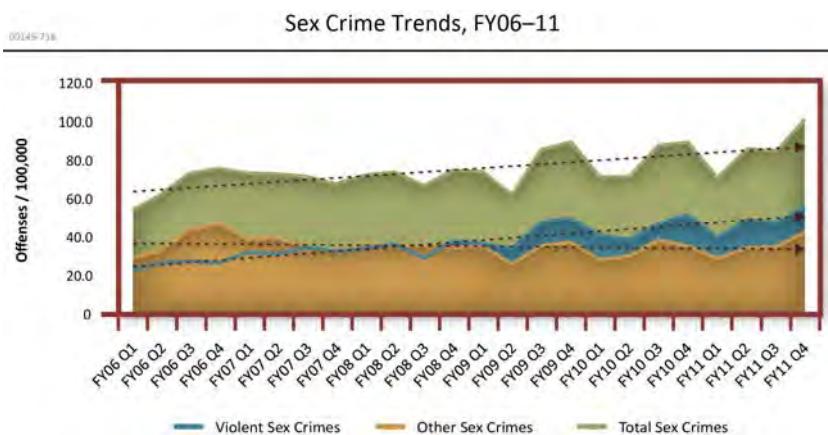


Figure III-28: FY06–11 Quarterly Sex Crime Trends

of command with senior NCO oversight and development of Soldier buddy teams. Barracks visitation policies too must provide for appropriate restrictions limiting visitor numbers, visiting hours, underage visitors, permissive activities and alcohol availability / quantity.

even more isolation.¹³ This phenomenon is even more prevalent for young female civilians visiting the barracks (or other high-density housing), who do not have an established social network and, therefore, are generally more vulnerable to victimization. Mitigation requires command emphasis. New Soldiers must be sponsored and quickly integrated into a formal chain

(d) Risk Factors of Sex Crime

From FY2006–11, alcohol was known to be involved in almost 63% of all rapes and aggravated sexual assaults. The relationship between these crimes and alcohol, however, is most likely underreported for several reasons, including the fact that victims may not report either the assault or alcohol consumption due to fears that they may be investigated for a collateral offense (such as underage drinking or violation of a general order). Law enforcement, however, does not normally title victims for alcohol-related offenses when investigating violent sexual crimes—the exclusive focus of these investigations is on the offender and the offense itself. Further, in approximately 20% of these crimes, alcohol usage is reported by law enforcement as “unknown,” which further obfuscates the extent of alcohol involvement. Recent changes in CID policy requiring that specific data must be included prior to closing an investigation will improve alcohol related reporting.²⁷⁴

Drug involvement was reported in only a small fraction of sex investigations. Victims do not frequently admit to voluntary drug use and toxicology testing performed to determine [recreational / intentional] drug incapacitation of the victim is often performed long after the drug would show up on a toxicology report. For example, the prescription sleep drug Ambien is suspected to frequently be involved in violent sex crimes. However, Ambien can only be detected for approximately six hours after ingestion and is usually out of a victim’s system long before either the offense is reported to law enforcement or the victim seeks medical attention.

Based on a review of FY2011 offenses, approximately 54% of all rapes and aggravated sexual assaults occurred in high-density housing (e.g., barracks, training dormitories, hotels and CHUs). This indicates that the occurrence of sexual assault in high-density housing, particularly military barracks, remains a serious issue. It is invariably linked to an environment conducive to alcohol-related socialization, common to barracks life, but also occurring at parties at private residences on and off the installation. Key components in both these scenarios include the opportunity for incapacitation and

¹³ For example, as of March 2011, female enlisted Soldiers comprised 29% of CMF 92, Supply and Services; 28% of CMF 68, Medical; and 24% of CMF 74, CBRN and are often integrated into predominantly male maneuver units.

seclusion of potential victims. During the course of the party, the incapacitated victim is typically removed to a separate room / bedroom where the crime is later committed in isolation.

Although females compose only 14% of the Force, they compose 95% of all victims of violent sex crimes. Analysis regarding “time in service” and “victim age” indicates that it is predominantly young (18–22 year-old) females within the first 18 months of service. The charts at figure III-29 illustrate the effects of these two risk factors on violent sex crime (time in service at top chart and victim age at bottom). The top chart provides data from a random selection of 596 female victims (E1–E4 as color coded) based on time in service for a range of periods including: less than 6-months, 6-months to 1 year, 1 year to 1.5 years, etc. The analysis found: 65 victims (11%)

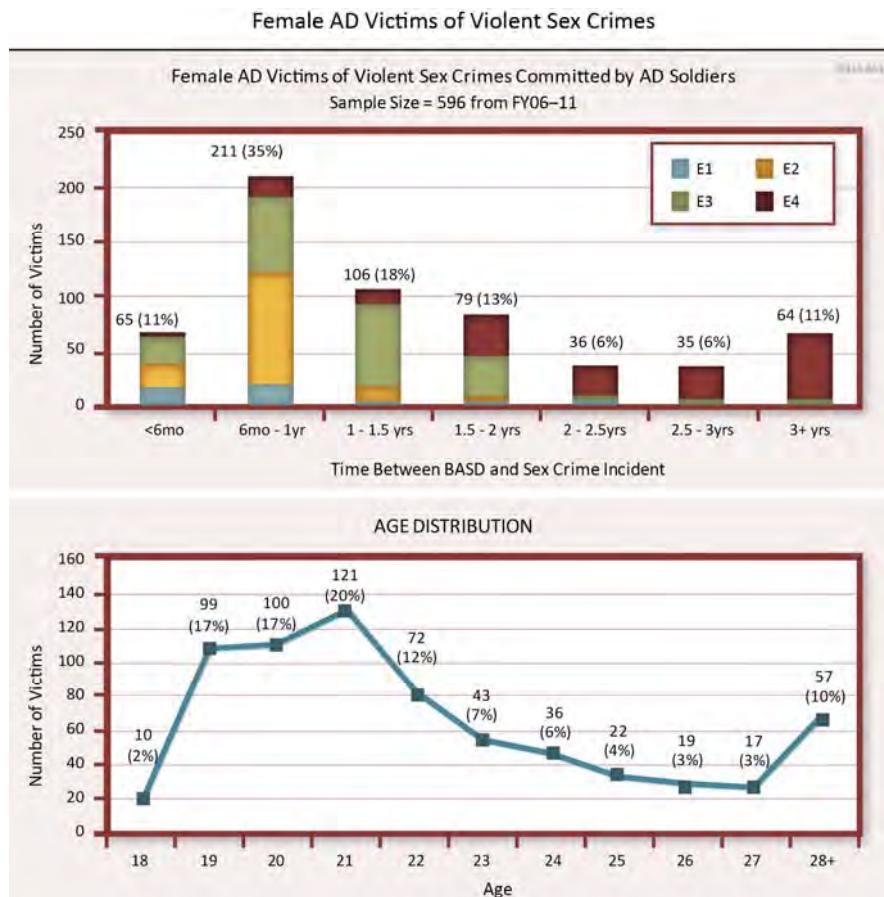


Figure III-29: Female AD Victims of Violent Sex Crimes

were sexually assaulted in the first 6 months of service, primarily involving E1–E3; 211 victims (35%) were sexually assaulted between 6 months and 1 year, primarily involving E1–E3; 106 victims (18%) were sexually assaulted between 1 and 1.5 years, primarily E3; the remaining demographics apportioned in periods up to 3 or more years. There are some key conclusions that can be drawn from this analysis. The first two periods and, likely the third period, represent transition periods: the first period, a transition to basic combat training; the second period, a transition to the first unit; and possibly the third period, to the first deployment. The second chart highlights victim ages, with 56% of the victims 18–21 years old and 68% 18–22. These transitional periods combine risk factors of limited supervision and immaturity to increase victim vulnerability among a predominantly male population in an environment associated with alcohol-related events in high density housing.

These findings regarding time in service and age are consistent with an analysis of victim-offender relationships. Approximately 97% of all victims of violent sex crime at least casually knew their attacker. In fact, 62% of the relationships the victims were acquaintances (e.g., co-workers, co-habitants of high density housing), followed by 14% spousal, 13% dependent child, 5% significant other, 3% other familial and 3% stranger. What is telling among these data is that, contrary to popular belief, most violent sex crimes are committed by acquaintances rather than by a stranger or significant other (e.g., such as a

boyfriend or date). In a military environment, these are crimes committed predominantly among loosely structured living standards (e.g., weekend parties in the barracks).

VIGNETTE— OPPORTUNITY AND ISOLATION

A 20-year-old civilian female attended a party adjacent to a barracks and became extremely intoxicated. After seeing the female become sick and vomit, a Corporal escorted her to his barracks room. After vomiting several times on her pants, she removed them and then lost consciousness on the Corporal's bed. She later regained consciousness with the Corporal removing the rest of her clothing. She again lost consciousness and later regained consciousness to a PFC, who also attended the party, sexually assaulting her. The young female awoke the next morning with the Corporal lying naked next to her. When asked if he engaged in sexual intercourse with her, he replied he had not but that the PFC had. The female was only able to recall limited events due to her level of intoxication.

If these risk factors were not convincing enough with respect to the vulnerability of young female Soldiers transitioning into permissive social environments, additional analysis regarding the timing of sex crime is further illustrative. The chart at figure III-30 depicts the occurrence of

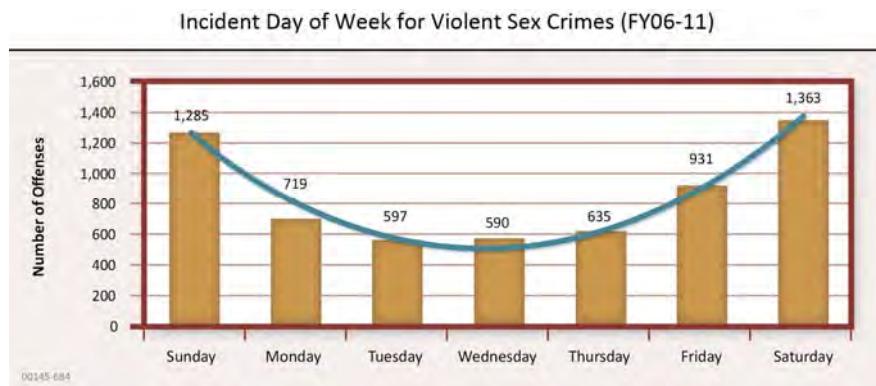


Figure III-30: Violent Sex Crimes by Day of Week

sex crime for each day of the week. The conclusion is obvious, the majority of this crime occurs on weekends (including holidays), which is consistent with increased social activity and reduced leader surveillance. With almost 60% of the offenses occurring Friday through Sunday, command emphasis and leadership guidance is required to ensure proper discipline and promote a safe environment in garrison outside of normal duty hours. Implementing barracks policies (visitation policies and alcohol availability / quantity limits), CQs or barracks over watch, and educating all Soldiers on risks and mitigation associated with sex crime will enhance health and discipline in military living and social environments.

While command emphasis on mitigating the effects of alcohol and improving leadership in barracks will certainly have a positive impact on reducing sex crimes, it is not enough. According to one study, “[s]tatistics show if a person has been assaulted in the past, they are more likely to be assaulted again while serving in the military. Perpetrators seem to know those people who are least likely to report. They tend to be able to pick out people who are more vulnerable and then victimize them.”²⁷⁵ This is especially true for young, newly arriving female Soldiers with under-developed social networks. Leaders can counter this risk factor by immediately integrating them into a formal chain of command, establishing appropriate leadership oversight and designating Soldier buddy teams. Commanders must ensure that new Soldiers, who are at increased risk for sex crime victimization (young female Soldiers), are appropriately mentored and monitored by experienced NCOs. This, coupled with enhanced discipline in high density housing, will provide additional safeguards and improve overall Soldier / unit discipline and readiness.

VIGNETTE—MULTIPLE FELONIES EQUATE TO MULTIPLE VICTIMS

A 25-year-old PFC raped another PFC while in her barracks room in June 2009. The PFC was never flagged and was allowed to PCS prior to any adverse adjudication. Approximately five months later he sexually assaulted another PFC while in her barracks room. The Soldier sexually assaulted and forcibly sodomized his pregnant girlfriend in October 2010 while at their off-post residence. In December 2010, the PFC sexually assaulted a fellow Soldier's six-year-old daughter on numerous occasions. The assaults occurred while the child was being taken care of by the PFC's girlfriend. He was subsequently admitted to the psychiatric ward for evaluation. He is currently pending prosecution for the sexual assaults associated with the second PFC, his girlfriend and the child.

LEARNING POINTS

- ★ Contrary to popular belief, 97% of all violent sex crime victims were acquainted with their attacker (e.g., coworker or fellow barracks resident).
- ★ 54% of all rapes and aggravated sexual assaults occur in the barracks; 63% are associated with alcohol use. This indicates a need for additional policy measures mitigating risk associated with high density housing.
- ★ Almost 60% of violent sex crimes occur between Friday and Sunday which is consistent with the incidence of alcohol-related sex crimes; this indicates a need for increased surveillance during off duty periods.
- ★ It is essential that commanders sponsor and quickly integrate young female Soldiers into a formal chain of command to reduce potential sex crime victimization (64% of rape victims are in the service less than 18 months).

VIGNETTE – SEXUAL ASSAULT EDUCATION AND TRAINING

IAW Article 120(c) of the Manual for Courts-Martial, aggravated sexual assault. Any person subject to this chapter who—

1. causes another person of any age to engage in a sexual act by—
 - a. threatening or placing that other person in fear (other than by threatening or placing that other person in fear that any person will be subjected to death, grievous bodily harm, or kidnapping); or
 - b. causing bodily harm; or
2. *engages in a sexual act with another person of any age if that other person is substantially incapacitated or substantially incapable of—*
 - a. *appraising the nature of the sexual act;*
 - b. *declining participation in the sexual act; or*
 - c. *communicating unwillingness to engage in the sexual act;*

—is guilty of aggravated sexual assault and shall be punished as a court-martial may direct.

Continued on next page

VIGNETTE – SEXUAL ASSAULT EDUCATION AND TRAINING – CONTINUED

The italicized portions above underpin a common scenario involving sexual assaults that occur in barracks and involve alcohol consumption. For example: a young female Soldier consumes alcohol while attending a party. After becoming intoxicated, she accompanies a male Soldier back to his room where they engage in sex. She wakes up the next day, remembering very little of the prior evening except for some recollection of having engaged in sex. She reports the event to a friend, who then contacts the chain of command or military police. Given the elements of the crime as listed above, the Army will initiate an investigation for Aggravated Sexual Assault. Although there may have been no intent to take advantage of her, the male Soldier engaged in sex with a fellow Soldier who was substantially incapable of appraising, declining participation or communicating unwillingness to engage in the sexual act.

Although there may not have been intent, there is obvious opportunity for confusion. The terms “substantially incapacitated” and “substantially incapable” are not clearly defined in the UCMJ and are open to interpretation. What is not open to interpretation is that the Army must ensure that Soldiers understand the consequences of potential alcohol-related criminal misconduct. Army leaders train Soldiers that drinking and driving are not compatible. And given the elements of proof of Article 120, they must also train Soldiers to ensure that they understand that consumption of alcohol can impair the judgment of both parties and that the consequences of an alcohol-related sex crime can have a significant and long-lasting impact on the victim, the subject and the Army.

(e) Investigative Findings for Sex Crime

Consistent with the civilian literature, reporting of sexual offenses (particularly for rape and aggravated sexual assault) include both legitimate and false allegations. A review of FBI data for sexual assaults across a seven-year period found that approximately 25% of sexual assaults referred to the FBI involved false allegations (based on post-arrest and post-conviction DNA exonerations).²⁷⁶ Another review, which examined findings from three separate studies, found that false allegations occurred from 41-50%, including Air Force research that found that among 1,218 rape cases, 45% were deemed false. The same article posited several key motivations behind false allegations, including: (1) a need for an alibi to compensate for problems arising from consensual sex, (2) in retribution for a perceived wrong such as rejection or betrayal, and (3) to satisfy a need for attention or other material gain. It further concluded that the veracity of the complaint must be questioned to preserve the presumption of innocence because “...sex crimes are the only crimes that do not require corroborating evidence for conviction.”²⁷⁷

Finding	FY06	FY07	FY08	FY09	FY10	FY11	FY06-11 Total
Founded	258	339	378	505	513	524	2,517 63%
Unfounded	169	183	210	183	184	146	1,075 27%
Insufficient Evidence	127	83	86	52	46	20	414 10%
Total	554	605	674	740	743	690	4,006 100%

Figure III-31: Violent Sex Crimes Investigative Findings (Soldier Victims Only)

Investigative results by CID from FY2006-11 were fairly consistent with research findings. The table at figure III-31 depicts investigative findings for violent sex crime during this period which are divided into three categories: founded, unfounded and insufficient evidence (supported by legal opines). These data are illustrative of the gap between legitimate and false allegations associated with sex crime

investigations. CID determined that, from among 4,006 alleged violent sex crimes, 63% were founded, 27% were unfounded and 10% were inconclusive based on insufficient evidence. This analysis supports several conclusions with respect to due diligence in the investigative and adjudication process: (1) every allegation must be thoroughly investigated as part of an impartial inquiry, (2) investigations must be conducted methodically to balance both the rights of the victim and alleged offender, and (3) commanders—responsible for meting out justice—must consider all evidence objectively during the referral and adjudication process. Although the reasons for the 84% decrease in insufficient evidence cases is unknown, it may at least partially explain the increase in violent sex crimes from FY2006-11.

(f) Sexual Harassment / Assault Response and Prevention (SHARP)

The Army's goal is to eliminate sexual assault and harassment by creating a climate where sexual misconduct is recognized and addressed in a way that respects the dignity of Soldiers and Family members. The Army's Sexual Harassment / Assault Prevention Strategy focuses on sexual assault prevention. Specific actions under the Prevention Strategy address prevention efforts directed at supporting victims, reducing the stigma of reporting and holding offenders accountable.

On 9 September 2008, the SA and CSA launched the "I. A.M. STRONG" Sexual Assault Campaign and Strategy. The cornerstone of the Army's prevention strategy is captured in its title where the letters I. A. M. stand for Intervene - Act - Motivate. The "I. A.M. STRONG" messaging features Soldiers as influential role models; provides peer-to-peer messages and outlines the Army's intent for all team members to personally take action to set a respectful standard of conduct and to protect their fellow community members.

This program was updated by ALARACT 182, *Sexual Harassment / Assault Response Prevention (SHARP) Program Implementation and Training*, 17 June 2010. This ALARACT provided additional guidance for unit-level training requirements, which authorized an MTT to train over 17,000 SHARP personnel across commands Army-wide. These training efforts continue to shape an Army culture of Soldier respect and accountability.²⁷⁸

LEARNING POINTS

- ★ Approximately 25% of sexual assaults referred to the FBI involved false allegations (based on post-arrest and post-conviction DNA exonerations).
- ★ Three separate studies found that false allegations occurred at a rate of 41-50%, including Air Force research that found that among 1,218 rape cases, 45% were deemed false.
- ★ CID determined that, from among 4,006 alleged violent sex crimes, 63% were founded, 27% were unfounded and 10% were inconclusive based on insufficient evidence.
- ★ Allegations of sex crimes do not infer guilt or innocence; CID must investigate all allegations to protect the victim and the alleged offender.

(6) AWOL / Desertion

Absent without leave (AWOL) and the related but more serious crime of desertion are among only a few crimes unique to military service. They are both serious crimes but desertion represents a felony crime which can have serious, long-lasting consequences that render Soldiers in fugitive status and adversely affect civilian employment (i.e., desertion is prejudicial during employment screening). These crimes often reflect the current stress on the Force, rising and falling in tandem with service-related

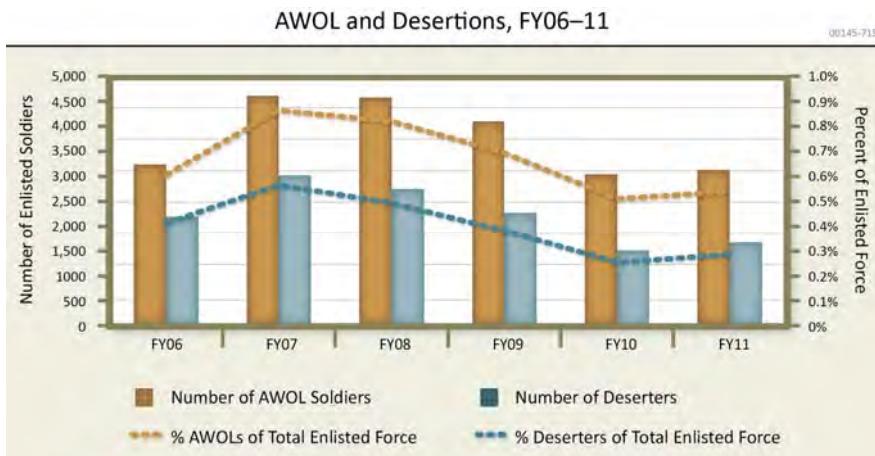


Figure III-32: AWOL and Desertions, FY2006-11

factors including OPTEMPO, deployments and hazardous duty. The fact that Army AWOL and desertion rates continue to generally trend downward reflects improvements and progress in reducing stress on the Force.

There was an overall decrease in AWOL and desertion offender rates from FY2006-11 with a small uptick from FY2010-

11, which still remained well below numbers reported in FY2007-09 (figure III-32). As expected, these two crimes mirrored each other with a consistently lower desertion rate that reflected a number of AWOL Soldiers who had returned to military control. A review of these data revealed that leaders are improving in AWOL and desertion reporting but still reflect a gap in law enforcement referrals and investigations. For example, of 18,010 Soldiers who deserted from FY2006-11, only 13,443 were reported to law enforcement. This represents a gap of 4,567 Soldiers reflected as deserters in manpower databases (G-1) but who have not been referred to law enforcement. Additionally, analysis indicated that a number of these offenses were committed by repeat offenders. Although leaders cannot completely eliminate these crimes, prompt reporting and investigations will undoubtedly increase the number of Soldiers who are returned to military control and either rehabilitated or separated as appropriate.

"Although the problem of AWOL / desertion is fairly constant, it tends to increase in magnitude during wartime – when the Army tends to increase its demands for troops and to lower its enlistment standards to meet that need."²⁷⁹

– Zita M. Simutis

Acting Technical Director, US Army Research Institute

2002

(a) AWOL

The offense rate for AWOL increased 4.2% (587 to 612) from FY2006-11. However, the real impact is more appropriately measured by the offender rate, which decreased by 11.8% (507 to 447) during the same period. This discrepancy is indicative of raw counts for offenses and offenders. AWOL offenses increased from 3,764 to 4,316 from FY2006-11 with a peak of 5,824 in FY2008, but offenders decreased from 3,250 to 3,155 during the same period with a peak of 4,671 in FY2007. This reflects a recurring problem across many disciplinary areas where progress in reducing offenses is hampered by a smaller subset of repeat offenders. For example, separating repeat AWOL offenders would reduce offense counts in FY2011 alone by 1,561 offenses.

(b) Desertion

The remainder of this subsection covers Soldier desertion, which has more serious and long-lasting effects on both the Army and the Soldiers who commit this crime. Desertion offense rates decreased 24.4% from FY2006-11 with offenses decreasing from 2,330 to 1,939, down from a peak of 3,228 in FY2007. Likewise, the offender rate decreased 31% in the same period with offenders decreasing from 2,205 to 1,673, down from a peak of 3,025 in FY2007. Similar to AWOL—but to a lesser degree—the discrepancy between offenders and offenses reflects a number of Soldiers, who upon return to military control, deserted again.

Contrary to popular belief, the majority of those who are placed in deserter status are eventually returned to military control. The United States Army Deserter Information Point (USADIP) reported 2,229 active arrest warrants for Soldiers who are currently at-large and remain in deserter status (as of August 2011). This number reflects Soldiers who have not yet been returned to military control and includes 529 Soldiers who deserted prior to FY2001. Figure III-33 provides the number of deserters (by year of desertion) who remain at-large. Unfortunately, these data only reflect law enforcement data (with completed USADIP packets) and does not account for a gap in reporting that may indicate a potential population of 4,567 Soldiers who were not reported to law enforcement and who will remain in a limbo pending a review by HQDA. If true, these Soldiers will remain in limbo until referred to law enforcement and enrolled in active warrant status for apprehension.

Number of Active Warrants for Deserters Based on Date of Warrant Issue

Current Total	FY11	FY10	FY09	FY08	FY07	FY06	FY05	FY04	FY03	FY02	FY01	Prior to FY01
2,229	883	232	133	111	80	56	50	36	43	42	34	529

Figure III-33: Number of Active Warrants for Desertion

Based on Army G-1 data (figure III-34), an analysis of desertion based on time in service revealed that desertion is most prevalent during the first 18 months of service when Soldiers are attending Initial Entry Training (IET) or assigned to their first unit. Of the 18,010 Soldiers who deserted from FY2006-11, approximately half (49%) deserted within their first year, 63% deserted in their first 18 months and 71% deserted in their first 24 months of service. The majority of the remaining desertions occurred at a decelerating rate through their first four years with less than 10% of all desertions occurring after five years of service. This analysis is consistent with trends in Chapter 11 separations in which desertions decrease as entry level separations increase (discussed under the Administrative Accountability section).

This inverse relationship between entry-level separation and desertion indicates a need to continue to assess and identify Soldiers whose entry-level performance and conduct may indicate a need to separate them from the service during IET (35% of all desertions) or upon the earliest indication that

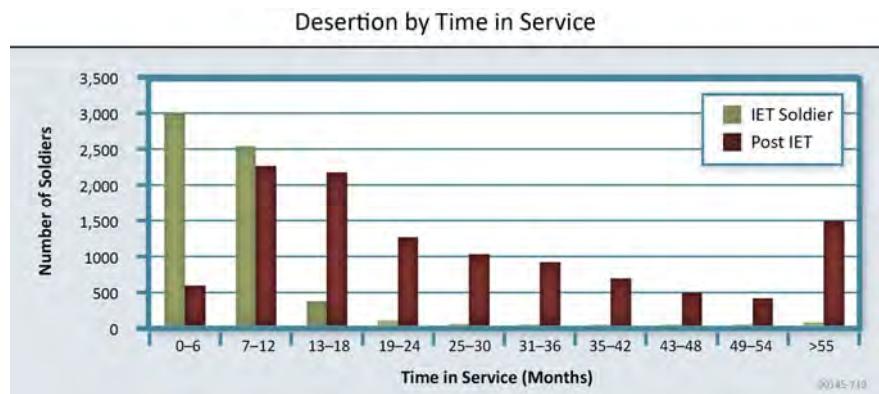


Figure III-34: Desertion by Time in Service, All Desertions from FY2006-11

they are unwilling to serve. This would prevent subsequent desertions that would require law enforcement involvement and expend additional leader time and resources. It is far more economical and less stressful on all involved if Soldiers can be separated using a Chapter 11 rather than being separated under Chapters 13/14. Regardless, any chapter action would be preferable to the increased risk associated with law enforcement apprehension.

The chart at figure III-35 clearly demonstrates that the Army policy for reporting and processing desertion is effective when implemented. For example, from a population of 4,359 Soldiers who were returned to military control in FY2008, 2,202 were arrested by civilian law enforcement as a result of the DFR warrant process while 2,133 surrendered to military control. Assuming that those who voluntarily surrender to military control remain constant, the number apprehended by civilian law enforcement is a direct result of commanders reporting deserters and completing DFR packets, which allows military law enforcement to work with its civilian counterpart to process and serve warrants.

Desertion Return-to-Military Control

Fiscal Year	DFRs Processed	Total RMC	Arrested by Civilian Authorities	Surrender to Civilian Authorities	Arrested by Military	Surrender to Military
2008	2,924	4,359	2,202	13	11	2,133
2009	2,510	3,531	2,119	10	12	1,390
2010	1,686	2,484	1,455	9	12	1,008
2011	2,198	2,146	1,382	25	44	695

Figure III-35: Desertion Return-to-Military Control (RMC)

New Army policy could dramatically streamline collaboration and subsequent efforts to return deserters by decreasing the time commanders must wait to classify a Soldier as a deserter. In the past commanders were required to wait 30 days before declaring an AWOL Soldier a deserter and to request the issuance of a warrant for law enforcement to arrest the Soldier. The policy, *Guidance for Commanders Request to Enter Deserter Warrants into the National Crime Information Center Database*, 26 September 2011, allows commanders to immediately declare Soldiers as deserters "...when [they] determine that absentee Soldiers have departed without the intent to return and are considered high risk."²⁸⁰ Although this policy will increase the number of Soldiers returned to military control and undoubtedly deter others from going AWOL, the use of a warrant prior to 30 days should be a deliberate command decision to avoid unnecessary high risk apprehensions.

Another draft policy is being considered that would allow the Army to separate Soldiers in absentia without returning them to military control. This will allow the Army to selectively separate Soldiers who have been absent for more than two years and who are not facing additional charges or who are not considered high risk. It proposes that Soldiers who are deserters or wanted for crimes including homicide, armed robbery, assault, sexual assault, illegal drug use or possess a top secret security clearance would be exempt from this in absentia separation. Soldiers eligible for discharge could receive a characterization of service of Other Than Honorable with a re-entry code that would preclude them from future service. The Army estimates that this policy alone would eliminate as many as 2,000 deserters. Discharging these Soldiers in absentia would save Army time and resources as well as allow USADIP and civilian law enforcement to focus on those high-risk Soldiers who are facing felony charges.

VIGNETTE—HIGH-RISK BEHAVIOR WHILE AWOL / IN DESERTION

While visiting his parents in July 2011, a divorced SFC with four deployments was drinking excessively and complaining about law enforcement and military issues. A short time later, the SFC committed suicide by shooting himself in the head. The SFC had a history of legal problems. In January 2009, he was apprehended for DUI (off-post). The charge was amended to careless driving; the SFC paid a \$100 fine. The DA Form 4833 reflects no further action by his unit. He was arrested for DUI (off-post) in March 2009. He was found guilty of reckless driving, sentenced to 6 months (suspended to 30 days) on the condition of good behavior and probation. The DA Form 4833 reflects no further action or ASAP referral. In May 2010, the SFC was arrested for attempted homicide when he became involved in a domestic dispute with his girlfriend and subsequently ran over her with his vehicle. In September 2010, the SFC was arrested for aggravated assault by local police. He was released on bond pending a court date. In November 2010, the SFC was listed as AWOL when he failed to report at court.

His duty status was changed to deserter in December 2010.

LEARNING POINTS

- ★ There were 18,010 Soldiers who deserted from FY2006-11. Of these 18,010 Soldiers, approximately half (49%) deserted within their first year, 63% deserted in their first 18 months and 71% deserted in their first 24 months of service.
- ★ The rate of Soldiers who deserted decreased 31% from FY2006-11 with offenders decreasing from 2,205 to 1,673, down from a peak of 3,025 in FY2007.
- ★ Separating repeat AWOL offenders would reduce offense counts in FY2011 alone by 1,561 offenses.
- ★ The vast majority of those who are placed in deserter status are eventually returned to military control. Of 4,359 Soldiers who were returned to military control in FY2008, 2,202 were arrested by civilian law enforcement as a result of the DFR warrant process while 2,133 surrendered to military control.
- ★ Deserter is most prevalent during the first 18 months of service when Soldiers are attending Initial Entry Training (IET) or assigned to their first unit.
- ★ New Army policy in FY2011 will dramatically streamline collaboration and subsequent efforts to return high-risk deserters by decreasing the time commanders must wait to classify a Soldier as a deserter and by expediting the warrant process.
- ★ Another Army policy in draft would allow the Army to separate Soldiers in absentia without returning them to military control. It is estimated that this policy alone would eliminate as many as 2,000 low-risk deserters and save considerable Army resources.

c. Multiple Felony Offenders

The Army has made progress in reducing the number of multiple felony offenders since the problem was introduced in the *Red Book*. As illustrated in the chart at figure III-36, it has reduced multiple felony offenders on active duty by 21% from its high in FY2008 of 6,181 to 4,877 by mid-FY2011. The chart further illustrates that the Army has successfully reduced this population to an 8-year low set in FY2004. The Army's progress in this area cannot be overstated because this calculation must take into account the revolving nature of the multiple felony offender population—as some are separated others join their ranks by offending again.¹⁴

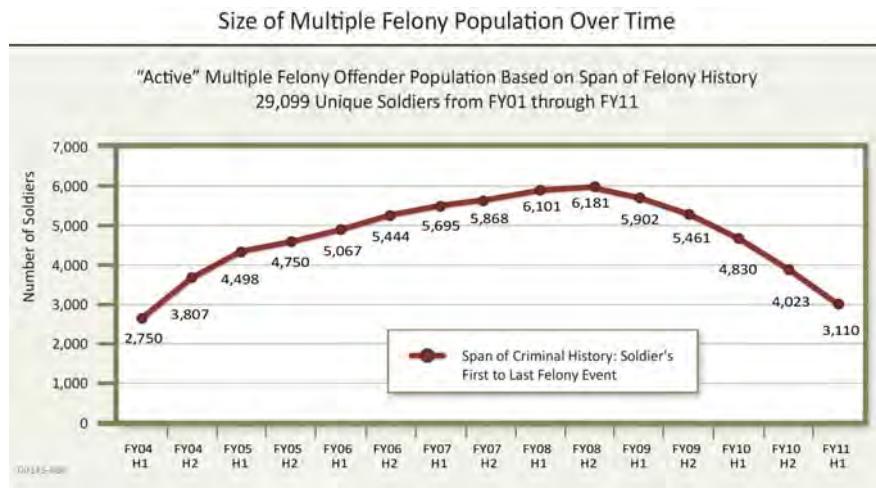


Figure III-36: Size of Multiple Felony Population Over Time

Nevertheless, there is a substantial number of multiple felony offenders still serving. Their impact on the Army must be promptly and appropriately addressed to prevent further erosion of good order and discipline and transmission of their criminal behavior to others. This section highlights the significance of the gaps in policy and inconsistent policy implementation that allow offenders to offend again, continue to serve, delays their separation and allows some to languish in an ambiguous status. Ultimately, multiple felony offenders represent a significant cost to the Army in terms of leader time, investigative resources, and unit readiness.

An analysis of the current status of the multiple felony offender population determined that of those who were deemed multiple felons (between FY2001-11), it was comprised of 29,099 Soldiers who were either separated, still serving or who remain in DFR status. It confirmed the findings of previous reports that accountability is not clear cut regarding Soldier discipline with respect to adjudication, reporting, timely separations, and appropriate Soldier status. Also, the analysis exposed a new gap regarding vague policy for the DFR process, which, as addressed under *AWOL / Desertion*, is open to variances in interpretation. For example, Soldiers who are in DFR status have not been separated from the Army but languish indefinitely *in absentia* until returned to military control and separated; although "off the books" their potential to offend again remains an Army problem.

¹⁴ Multiple felony offenders are based on closed, founded investigations that have received a legal opinion demonstrating that there is probable cause to title the Soldier (listed in the subject line) with the crime.

VIGNETTE— IMPACT OF MULTIPLE FELONY OFFENDERS ON LEADER TIME, ARMY RESOURCES, VICTIM READINESS

Shortly before deployment to Iraq in 2004, a Specialist was titled for simple assault stemming from a fight he was involved in while intoxicated. He was awarded a Purple Heart and a CAB while deployed. After returning from deployment, the Soldier was a subject in three separate alcohol-related incidents; a simple assault, aggravated assault and driving while impaired. No action was taken. Three months later (March 2006), the Soldier left the Service with an Honorable Discharge. After 11 months in the Inactive Reserves, the Soldier reentered the Active Component and was promoted to Sergeant in April 2008. One month later the Sergeant, while attending WLC, provided a false statement to CID alleging 40 Percocet were stolen in an attempt to obtain more Percocet. The Sergeant was removed from WLC. In April 2009 the Sergeant reenlisted for six years. In December 2009, the Sergeant was arrested for driving while intoxicated and snorting crushed hydrocodone. He received a General Officer Letter of Reprimand for this incident in April 2010. In May 2010, the Sergeant tested positive for marijuana while enrolled in the ASAP program and went AWOL for an unspecified period of time. The Sergeant was demoted to Specialist for going AWOL. The Soldier had two positive urinalysis tests (marijuana) in June and July 2010. The Soldier was finally separated with a general discharge for drug abuse in September 2010, which will prevent him from reentering active duty. In all, this Soldier committed at least 5 felonies and 6 misdemeanors during a 5-year period, with 1 felony and 3 misdemeanors prior to his 2006 ETS.

The chart at figure III-37 portrays the current status of the 29,099 multiple felony offenders identified from FY2001-11. As of August 2011, 17% (4,877) of these Soldiers were still serving on active duty; 68% (19,842) were administratively separated or had successfully completed their active duty obligation (ETS'd or retired); while 11% (3,126) remain in DFR status; and 4% (1,254) remain in an undetermined status because of gaps in data. With the exception of those in an undetermined status, each of these multiple felony offender populations is examined throughout the remainder of this subsection. Although Army analysis continues regarding those Soldiers in an undetermined status, this subset population represents a small number of Soldiers spanning over 10 years of data.

(1) Multiple Felony Offenders Still Serving

The 4,877 multiple felony offenders still serving committed at least two separate felony offenses during two or more unique crime events as well as a variety of other misdemeanor offenses. While their crime distribution ranges across the full set of violent and non-violent felony crime, nearly 40% committed at least one drug crime, 17% committed fraud / larceny, 11% committed aggravated assault, 9% committed a violent sex crime, and 8% committed desertion. In addition to committing at least two felony crimes, many Soldiers committed additional misdemeanor offenses. Among those who committed a misdemeanor offense, 21% committed assault and battery, 12% committed DUI offenses, 11% committed family abuse, 10%

Status of 29,099 Multiple Felony Offenders

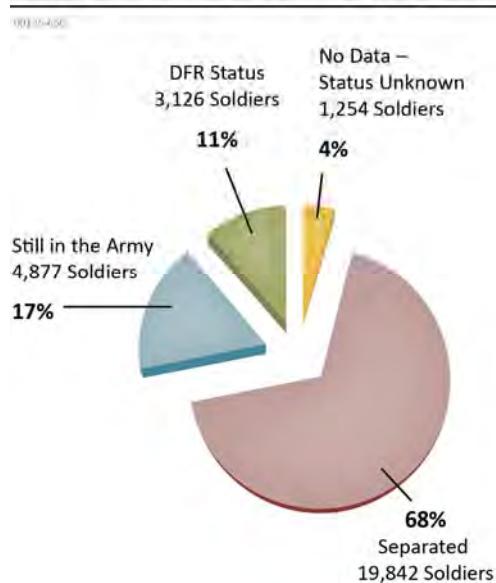


Figure III-37: Status of Multiple Felony Offenders

committed drunk and disorderly offense and 10% were AWOL. This offender population was further analyzed to examine the elapsed time between first and last crime event, the number of felony offenses committed and their current status or separation history. Each perspective illustrates the unique effects that this population has on the Army.



Figure III-38: Time Between First and Last Felony Events

Figure III-38 depicts the elapsed time between the first and last felony event, which provides the frequency and span of the offender's criminal history. Several conclusions can be drawn from this analysis.

Approximately 60% (2,922) of all multiple felony offenders committed at least two felonies in a single year as highlighted in the first bar. The compressed frequency of unique crimes occurring in less than one year indicates rapidly escalating high-risk behavior, common among Soldiers who are undergoing protracted disciplinary and administrative actions. This tight distribution indicates the need for enhanced surveillance and more restrictive control measures over these Soldiers during investigation and adjudication of felony crimes. Also, enhanced communication and collaboration among commanders, law enforcement and the legal community can expedite referrals and adjudications which could reduce the

number of multiple felonies that occur in a single year.

Second, periods between first and last events that exceed one year may indicate gaps in surveillance, detection and reporting systems intended to provide commanders with a 360° view of a Soldier's adjudication and referral history. Nevertheless, it certainly reflects a problem of recidivism among Soldiers who commit felony-level crime. It may also indicate inappropriate disciplinary or administrative actions during the first crime event that allowed the Soldier to offend again. This is true for the 40% of multiple felony offenders who offended again (or multiple times) at some point in time up to 5 years following their first crime event. Finally, the distribution of criminal history only provides a window into that high-risk behavior that was detected. For example, a Soldier who was detected illicitly using drugs multiple times is generally only detected based on the odds of being tested only once or twice a year.

VIGNETTE—DISCIPLINARY AND ADMINISTRATIVE MEASURES CAN PREVENT VICTIMIZATION

A 21-year-old SPC was convicted of the 2006 murder of a detainee (at the direction of his squad leader). The SPC was found guilty in a General Court-Martial, sentenced to nine months confinement, reduced to PVT and allowed to continue to serve. As a SSG in 2011 he remains under investigation for the following felony offenses: (1) an August 2009 rape and cruelty / maltreatment of a subordinate and (2) an October 2009 rape and cruelty / maltreatment of a subordinate. Unit leadership is currently adjudicating these crimes. The SSG has deployed four times.

An analysis of the number of unique felony crimes committed as compared to the number of individuals who commit these crimes is a good measure of the impact of these offenders on the Force. The table at figure III-39 depicts the number of felony cases per offender (some cases may involve multiple felonies). Of the 4,877 multiple felony offenders, the majority of them (or 81%) committed two felony offenses spanning two separate criminal events, while the

remaining 19% committed three or more felony offenses arising from separate events. This clearly indicates that command action taken after the first felony offense did not prevent the offender from reoffending. Moreover, it begs the question of whether or not any of these Soldiers—particularly the 940 Soldiers who committed three or more separate felony crimes—are fit or disciplined enough to serve among the vast majority of professionals who honorably serve this Nation.

Perhaps the most perplexing data in the analysis of multiple felony offenders is highlighted in the chart at figure III-39. This analysis revealed that 8% (382) of the multiple felony offenders had a break in service with the majority representing a break in service based on an adverse adjudication. Most notable among those were 313 Soldiers who were dropped from the rolls under deserter status and approximately 10 who were previously separated for misconduct. Although such a low number, it indicates the larger problem of gaps in policy and processes that allowed them to reenter the Army and continue to serve. This may have occurred via a variety of factors but it most likely was the result of an inappropriate characterization of service and re-entry code classification on the DD Form 214 (*Certificate of Release or Discharge from Active Duty*).

(2) Separation and Disposition of Multiple Felony Offenders

The discipline, separation and disposition of 19,842 multiple felony offenders represent a good news story because it indicates a significant decrease in the number of multiple felony offenders since the publication of *The Red Book*. Prior to its publication, only 61% of the multiple offender population (spanning from FY2001-09) had been separated. As of August 2011, the number of Soldiers separated had increased to 83%. The chart at figure III-40 illustrates the categories under which these multiple felony offenders were separated across the entire span (from FY2001-11). Approximately 64% (12,606) of these Soldiers were separated for misconduct under Chapter 14, 13% (2,546) were separated in lieu of court martial under Chapter 10 and 1.4% (272) were separated following courts-martial. The adverse disciplinary and administrative measures appropriately taken against the majority of multiple felony offenders have a positive impact on overall discipline. They not only remove Soldiers exhibiting criminal and high-risk behavior from the Army but reduce the transmission of high-risk behavior across units and communities, and when their service is appropriately characterized, prevent their re-entry.



Figure III-39: Profile of 4,877 Multiple Felony Offenders Who are Still in the Army

Consistent with findings from the analysis of other gaps, progress is underway but there are still areas for improvement. Separations for a minority of multiple felony offenders resulted in an inappropriate disposition.

Approximately 12% (2,315) were allowed to ETS or retire, which

confirms gaps already identified in Army transition processes. This means that offenders have departed active duty with an inappropriate characterization of service and re-entry code that will allow them to reenter the Army at some time in the future. Additionally, for a small number of Soldiers, it highlights potential gaps in determining retirement eligibility. One has to question the decision to allow a Soldier with multiple felony offenses to successfully retire from service.

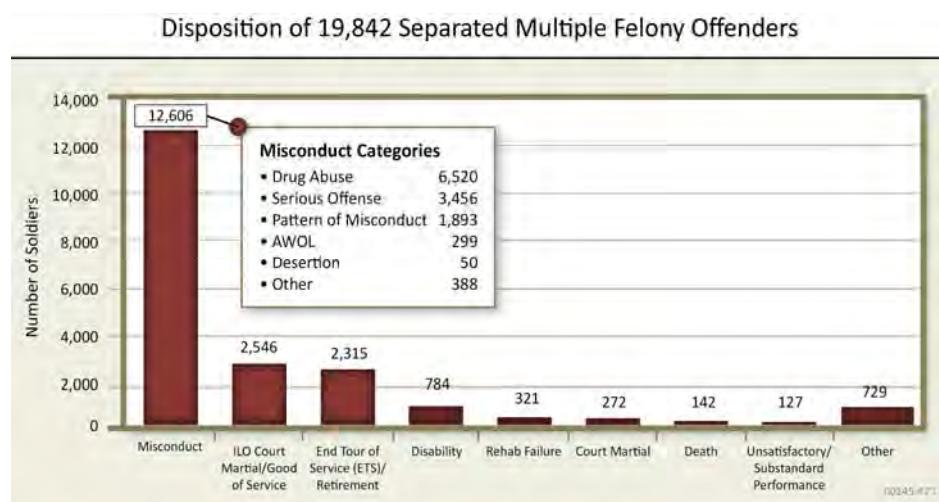


Figure III-40: Disposition of 19,842 Separated Multiple Felony Offenders

Perhaps more concerning—and certainly more perplexing—is the number of multiple felony offenders who died while on active duty. There were 142 Soldiers among the multiple felony population that died while on active duty from FY2001-11. Of these 142 Soldiers, 128 were associated with non-hostile deaths. As discussed under *Death Investigations*, 88% (112 of 128) of these deaths involved high-risk behavior with 41 committing suicide and 71 dying as a result of a drug overdose, DUI-related accident or as a victim of homicide. This is an extremely high number of deaths per capita, which equates to approximately 440 per 100,000 compared to an average of 42 per 100,000 for the Army population at large. This confirms other data which indicate that multiple felony offenders are at increased risk for more severe outcomes, including death.

On a final note, results of this analysis are based on enlisted AD personnel information only. It is possible that separated AC Soldiers joined the Reserve Component. Therefore, the number of multiple felony offenders still in the Army is slightly understated and the number of separated multiple felony offenders slightly overstated. In other words, the Army may have inadvertently transferred some multiple felony offenders into the Reserve Component due to gaps in characterization of service and re-entry code. Access to RC personnel data was not available for inclusion in this report.

(3) Separation and Disposition of Multiple Drug Offenders

Although the population of 29,099 multiple felony offenders includes the multiple and serial drug offenders still serving and separated, additional analysis of this subpopulation provides more concrete evidence of both progress and remaining gaps in policy implementation. There were 12,933 multiple and serial drug offenders from FY2001-11. Of this number, 58% (7,508) were separated for misconduct under Chapter 14; 9% (1,168) were separated in lieu of court-martial; 9% (1,123) are in DFR status; 7% (877) ETS'd; 6% (783) are still serving; and 3% (420) were in an undetermined status due to gaps in data. Although the analysis and findings of this subpopulation parallels that of the larger population of multiple felony offenders, statistics regarding this population lends additional credibility to those

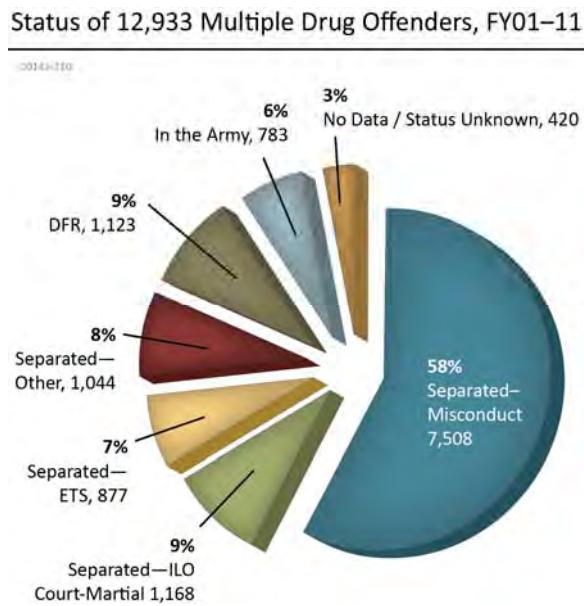


Figure III-41: Status of Multiple Drug Offenders

publication of the *Red Book*, separations with respect to this population have increased from 61% (from FY2001-09) to 83% as of August 2011. Although the gap has narrowed, there is still more work to do. Inappropriate disciplinary and administrative accountability of a relatively small number of multiple felony offenders may be the result of two critical components: (1) lack of command visibility and (2) a need for enhanced education. At times, commanders may not have the requisite visibility of the criminal history of multiple felony offenders when adjudicating them (e.g., previous criminal offenses, prior adjudication and disposition, or other indicators of high-risk behavior). Even when commanders have the requisite information regarding an offender, they may not be attuned to the potential for repeat offenses, the potential transmission of high-risk behavior to others and full awareness of the impact of these offenses on victims. Critical information such as recidivism rates (e.g., 36% of AD Soldiers who tested positive once in FY2010 will test positive a second time, and 47% of the population that tested twice will test positive a third time) may better inform disciplinary and administrative decisions. However, based on current progress, leader visibility and education continues to improve.

conclusions posited earlier. Drug offenses are generally clear cut with respect to investigative findings because they are based on scientific testing, which provides more convincing evidence during adjudication. This analysis provides additional confirmation that the Army is making real progress in policy implementation regarding appropriate surveillance, detection and response systems but still has some remaining gaps that must be fully closed. For example, almost half of the 783 multiple drug offenders remaining on active duty committed their last drug offense in FY2011, which suggests that the Army continues to improve adjudication and separation of multiple drug offenders.

Army leaders, particularly commanders, have made real and measurable progress in reducing the multiple felony offender population. Since the

LEARNING POINTS

- ★ The number of multiple felony offender deaths per capita equates to approximately 440 per 100,000 compared to an average of 42 per 100,000 for the Army population at large. This confirms other data which indicate that multiple felony offenders are at increased risk for more severe outcomes, including death.
- ★ Inappropriate disciplinary and administrative actions taken against a number of multiple felony offenders may be the result of two critical components: (1) lack of command visibility and (2) a need for enhanced education on disciplinary and administrative actions.
- ★ While significant progress has been made to date to reduce the multiple felony offender population on active duty, 4,877 remain on active duty as of FY2011.
- ★ Approximately 60% of all multiple felony offenders committed their second or third offense within the same year as their first offense, indicating a need for greater collaboration between commanders and program managers and increased surveillance during subsequent adjudication.

- Appropriate characterization of service (e.g., OTH discharge) and re-entry code would effectively eliminate Soldiers adversely adjudicated for criminal misconduct from transitioning to the RC or re-entering active duty.

d. Death Investigations

(1) Homicide and Attempted Murder

This section reviews homicide (including murder, voluntary and involuntary manslaughter, negligent homicide) and attempted murder. There were 576 homicides committed by 430 Soldiers and 231 attempted murders by 107 Soldiers from FY2006-11. Homicide has trended sideways from FY2006-11 but showed an uptick from FY2010-11 with an increase from 12 to 15 offenses and from 8 to 12 offenders per 100,000 Soldiers. Attempted murder decreased from 9 to 5 offenses per 100,000 but increased from 2 to 3 offenders per 100,000 from FY2006-11. It decreased significantly from FY2010-11, primarily due to the Fort Hood incident which alone accounted for 40 offenses of attempted murder.

The chart at figure III-42 illustrates trends for intentional and unintentional homicides and attempted murders from FY2006-11. Homicide (murder and voluntary manslaughter) and attempted murder all share an element of intent to kill or inflict grievous bodily harm, while the remaining two categories (involuntary manslaughter and negligent homicide) represent deaths caused by either culpable or simple negligence. The data for these crimes are too small to provide meaningful analysis but certainly did not demonstrate any anomalous activity. Crimes under the intentional homicide category generally undulated between 71 and 135 offenses in each of the 6 years with a high of 135 in FY2010, again reflecting those alleged crimes committed during the Fort Hood incident. Similarly, crimes under the unintentional felony category varied between 25 and 39 across the same period. Although the criminal intent was obvious among crimes in the first category, it is worth noting that crimes in the second category were still committed as a direct result of high-risk behavior (e.g., DUI, Russian roulette, accidental shooting and drug distribution).

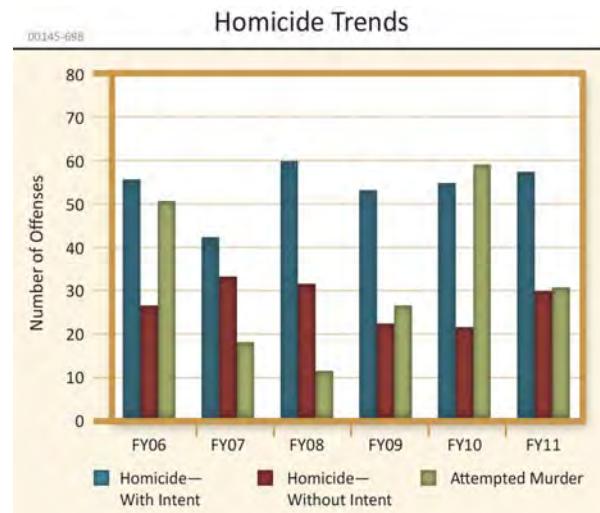


Figure III-42: Homicide and Attempted Murder Offenses

With the notable exceptions of the mass homicides associated with the Combat Stress Clinic (Camp Victory, Iraq) and Fort Hood shooting incident, a review of the risk factors involved in homicide and attempted murder for FY2011 is similar to those in each year from FY2006-10. Of the 104 Soldiers who committed homicide or attempted murder in FY2011, 51% had prior criminal offenses vs. 6% of the Army at large. The vast majority or 72% (68 of 94 with known deployment histories) of these offenders never deployed (24) or deployed one time (44). Consistent with the offender distribution for all crime, the majority of offenders were junior Soldiers with 68% (71) E1-E4, followed by 26% (27) E5-E7 and 6% (6) spanning the officer ranks of CW2, 2LT / 1LT and CPT. They committed these crimes against 125 victims of which approximately 45 were strangers, while approximately 80 had varying degrees of relationship with the offenders including acquaintances and family. The most prevalent means were

firearm (73), followed by motor vehicle (21), and knife (18). Most of these risk factors are fairly common among these types of violent crime (e.g., relatively even split between stranger and known relationship).

VIGNETTE—LOADED WEAPON & RECKLESS CONDUCT

Three 2LTs intended to go to a firearms range when their plans were impacted by inclement weather. While playing video games, one 2LT stood up, rotated the cylinder of his revolver, commented “I’m feeling lucky,” placed the revolver under his chin and pulled the trigger. The revolver discharged the single loaded round. He died the following day. Toxicology results indicated he had a BAC of 0.138. The county coroner classified his death as a suicide.

The deceased 2LT arrived to his unit three weeks earlier while the unit was on block leave. There was no history of personal or family issues and no known drug/alcohol issues. While no suicide note was found, a “to do” list with “shoot self” was found among his personal belongings. Two weeks prior to the suicide, another officer reported the deceased 2LT had shot at him. CID investigators were unable to gain further information on this alleged shooting as the victim invoked his rights and declined to discuss the incident.

LEARNING POINTS

- ★ Although the number of homicides committed in the Army each year remains relatively low, incidents such as the combat stress clinic and Fort Hood shooting incident highlight the affect that a single individual can have on the Force.

(2) Suicide

This section provides additional information on suicide related specifically to high-risk behavior, which complements a more thorough review of suicide provided in Chapter 2. The chart at figure III-43 provides an overall summary of their offense history in addition to alcohol / drug use during the suicide event (AD suicides from FY2006-11). There is

a significant relationship between both risk factors (prior offenses and drug / alcohol use) and suicide. Prior offenses among suicide victims averaged 29% during this period while alcohol / drug use at the time of death averaged 35%.¹⁵ Criminal history data are also consistent with the association of high-risk behavior among other high-risk accidental and undetermined deaths. As reported under *Separation and Disposition of Multiple Felony Offenders*, Soldiers who committed multiple felony offenses were at significantly higher risk for severe outcomes including death. Multiple felony offender deaths were 440 per 100,000 as compared to 42 per 100,000 for the population at large. Consequently, reducing high-risk behavior in general could have a desired effect of potentially reducing at least a small portion of suicides.

Fiscal Year	Number of AD Suicides	Victims with Criminal History		Alcohol/Drug Use at Time of Suicide	
FY06	99	21	21%	41	41%
FY07	103	24	23%	32	31%
FY08	137	37	27%	46	34%
FY09	159	53	33%	44	28%
FY10	164	54	33%	93	57%
FY11	162	51	31%	36	22%
FY06-11 Total	824	240	29%	292	35%

Figure III-43: Criminal History and Alcohol / Drug Involvement in AD Suicides

¹⁵ Alcohol and drug numbers are known to be under reported due to gaps in law enforcement data, which in many cases are simply documented as unknown.

A review of Soldiers who received health and conduct accession waivers from FY2006-10 revealed no significant relationship between waivers and suicides. Approximately 16% of suicide victims from FY2006-10 had received an accession waiver. However, this percentage is true of all accessions from FY2006-10, which means that it is unlikely that waivers provide a meaningful indicator of potential suicide.

On the other hand, there is a significant relationship between investigations and suicide. Potential legal actions that impugn Soldiers' reputations and careers, affect family relationships and may ultimately result in incarceration, place them at significantly higher risk for suicide and other high-risk behavior. Approximately 16% of all suicides involved subjects of on-going criminal investigations or pending adjudications for criminal offenses. These investigations and legal actions are almost exclusively related to felony crimes. Suicides linked to child pornography investigations provide a good example of this linkage. About 20% of investigative-related suicides occurred during the investigation of child pornography crime. This particular crime more clearly highlights stressors involved with serious felony investigations because of the shame associated with this crime; the likely adverse impact on family relationships and career / retirement; and the potential length of incarceration.

To address the risks associated with legal actions and suicide, the PMG published new policy, *High-risk Notification*, 6 May 2011, regarding the topic of investigation-related suicides and other high-risk behavior. This risk notification is provided by CID investigators to commanders when Soldiers are under serious felony investigations to emphasize the increased risk for self harm. In addition to criminal investigations, other investigations such as commander inquiries and non-judicial punishment increase the risk for self harm and often are suicide triggering events.²⁸¹

LEARNING POINTS

- ❖ Prior offenses among suicide victims averaged 29% while alcohol / drug use at the time of death averaged 35% (FY2006-11).
- ❖ Approximately 16% of all suicides involved subjects of on-going criminal investigations or pending adjudications for criminal offenses.
- ❖ It is unlikely that accession waivers provide a meaningful indicator of potential suicide.

(3) Equivocal Deaths

The discussion of equivocal deaths must begin with a discussion regarding the determination of cause and manner of death. The cause of death basically describes what happened to cause the fatality and the manner of death describes how it happened, whether homicide, suicide, natural, accidental, or undetermined. While the cause of death is generally clear cut, determining the manner of death can be challenging because it requires an investigation to establish intent. For example, cause of death may be gunshot wound to the head whereas the manner of death may be homicide, accidental or suicide depending on the determination of intent behind the act. Manner of death may be even more complicated when investigating equivocal deaths or those deaths related to high-risk behavior in which the manner of death is not readily apparent (e.g., drug toxicity deaths, vehicle accidents).

Also, as reported in the *Red Book*, there are differences in how death investigations are conducted and how the "manner of death" is determined across the nation. Law enforcement investigators work with medical examiners to determine the manner of death. Although final determination of the manner of death is based on the totality of the evidence, discerning the victim's intent (e.g., witness testimony,

notes or other communication) can be challenging. With the absence of intent, the manner of death from drug overdoses, traffic fatalities and other risk related deaths are routinely classified as accidental and undetermined. A 2006 report concluded that "...the magnitude of misclassification is substantial, with 20-30% of suicides inaccurately assigned as accidental or undetermined."²⁸² Additionally, the disparity in protocols among law enforcement agencies and medical examiners nationwide makes reporting deaths of RC Soldiers not on active duty difficult and further degrades data reliability.

The distinction of high-risk behavior has also been addressed as an essential aspect in determining manner of death. A guide by the National Association of Medical Examiners highlighted the changing nature of high-risk behavior and its subsequent impact in determining manner of death, "Risk-taking behavior poses challenges when classifying manner of death. More and more, people are engaging in risky sports, recreational activities, and other personal behaviors. Injury or death, when it occurs during such activities, is not entirely unexpected, prompting the argument that such deaths may not truly be 'accidents.'"²⁸³

Manner of death determination nationally (and in the military) has morphed over the last couple of decades from a classification of accidental to involuntary manslaughter or negligent homicide based on high-risk behavior involved in the fatality. For example, DUI-related deaths have increasingly been classified as involuntary manslaughter or negligent homicide since the late 1980s. More recently, boating fatalities associated with alcohol use have generally been classified as involuntary manslaughter or negligent homicide since mid-2000s. These kinds of trends will probably continue to impact classification of other types of fatalities which involve high-risk behavior or unacceptable risk that is increasingly being linked to negligence. Military training accidents involving high-risk behavior or associated with unacceptable risks (lack of preparation and risk mitigation) may be classified as negligent homicide.

(a) Accidental and Undetermined Deaths

There were a total of 662 accidental and undetermined deaths investigated by CID from FY2006-11, which were caused by a variety of factors including traffic, alcohol and drugs, weapons or multiple factors. At least half of these deaths are related to high-risk behavior. The chart at figure III-44 depicts 312 drug toxicity deaths which were the result of high-risk behavior. The pie chart breaks out these deaths into three categories: drug toxicity deaths involving a single drug (red), drug toxicity deaths involving two or more drugs (blue) and drug toxicity deaths involving alcohol (green). Of the 312 deaths, 68% (214) involved prescription medication (oxys most prevalent). Of these 214, 48% (103) were not prescribed to the victim at the time of death. Drug toxicity deaths, moreover, have trended upward during this period from 22 in FY2006 to 56 in FY2010. There are 32 prescription-related deaths so far in FY2011 with 46 deaths still under investigation as of the publication of this report.

Based on the ratio of prescription to other drug toxicity deaths (adjudicated in FY2011), it is likely that there will be approximately 60 prescription-related deaths in FY2011, continuing the trend upward.

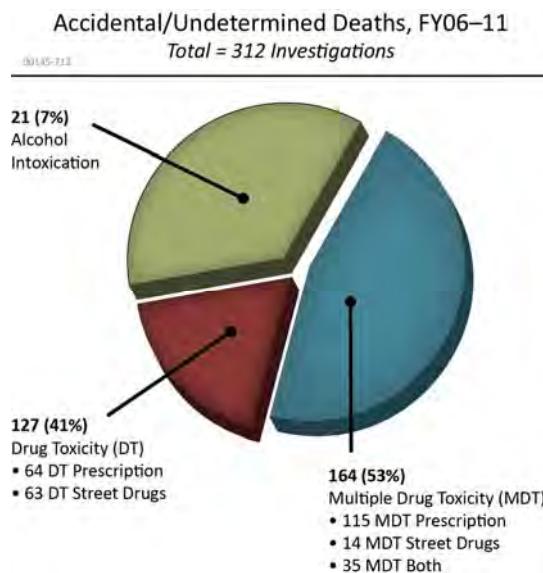


Figure III-44: Accidental / Undetermined Deaths, FY06-11

As a result of a growing concern regarding medication-related deaths (discussed in Chapter II), the Army is working to develop a Drug Take-Back Program to reduce the available quantity of prescription medication throughout the Force. In CY2010, at least 63% of attempted Army suicides were associated with drug or alcohol overdose. As of CY2011, 625 Soldiers have been treated for drug overdose in an emergency room setting.²⁸⁴ Further, of 124 accidental or undetermined deaths under investigation in FY2010, 45% involved the use of prescription drugs. By these metrics alone, reducing the availability of prescription medication and the opportunity for illicit use makes this one of the most impactful emerging Army policies. Given that the Army has limited the duration of authorized use, this policy is even more impactful in reducing the risk associated with a ubiquity of unused medications.

A review of street drug toxicity revealed that only a few illegal drugs are implicated in the vast majority of all deaths. Approximately 37% of street drug-related deaths involved heroine, closely followed by 36% involving huffing and 14% involving cocaine. The remainder involved a variety of street drugs including Ecstasy, LSD and PCP. Although street drug use is gradually losing ground to illicit use of prescription medication, the fact that it is more readily susceptible to surveillance and detection may further reduce its impact on the Force. For example, the new policy to increase drug suppression teams on the largest installations (based on populations served) should dramatically increase reporting of street drug use while reducing actual illicit use by mid-FY2012.

(b) Death Trends FY2001-11

As illustrated at figure III-45, active duty deaths have trended upward since FY2001. Although murder has been trending sideways in a tight band, suicides and equivocal deaths (accidental and undetermined) have increased over time. The increase in suicides has been dramatic since FY2004 but may be stabilizing at approximately 160 deaths per annum. However, equivocal death trends from FY2010-11 can be misleading. The increase in undetermined deaths countered by the decrease in accidental deaths is predominantly caused by changes and delays in manner of death determination. For example, there are approximately 64 death cases among these categories that were still pending determination as of November 2011. Regardless, combined numbers from these two classifications increased from 92 to 137 from FY2006-11 with a low of 81 in FY2008 and a new high in FY2011.

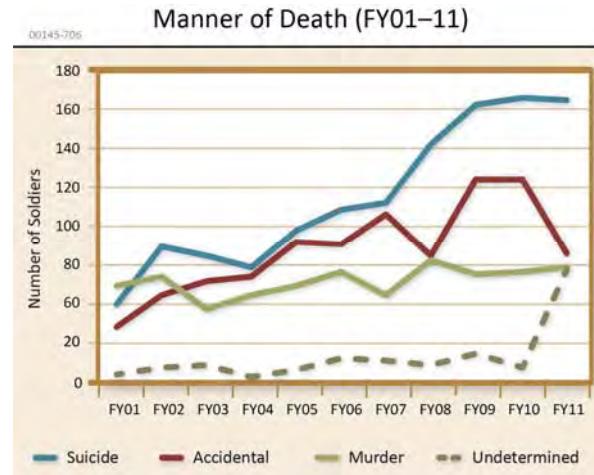


Figure III-45: Manner of Death, FY01-11

LEARNING POINTS

- ❖ The increase in suicides has been dramatic since FY2004 but may be stabilizing at approximately 160 deaths per annum.
- ❖ With the absence of intent, the manner of death from drug overdoses, traffic fatalities and other risk related deaths are routinely classified as accidental and undetermined which may under report high-risk and suicide related deaths.

- ★ In CY2010, at least 63% of attempted Army suicides were associated with drug or alcohol overdose. As of CY2011, 625 Soldiers have been treated for drug overdose in an emergency room setting.
- ★ Of the 312 drug toxicity deaths, 68% (214) involved prescription medication. Of these 214, 48% (103) were not prescribed to the victim at the time of death.
- ★ A new policy increasing drug suppression teams on the largest installations (based on populations served) will dramatically increase reporting of street drug use while reducing actual illicit use by mid-FY2012.

e. Family Abuse

The Army has experienced a dramatic increase in domestic violence / child abuse referrals to the Family Advocacy Program (FAP), which reflects a dramatic increase in leader surveillance, detection and response to potential domestic abuse offenses. Total referral numbers for Soldier offenders of domestic violence increased by 50% (4,827 to 7,228), while child abuse referrals increased by 62% (3,172 to 5,149) from FY2008-11.¹⁶ This large increase in referrals may be one of the leading indicators of stress on the Force. The Army's capability and capacity to refer, screen, substantiate and treat a growing number of Soldiers and Families affected by these incidents is a good news story.

Domestic violence and child abuse crimes present another concern for the Army as the number of incidents has increased in recent years. The chart at figure III-46 represents only substantiated crimes, which reflect an overall increase of 85% (1,459 to 2,699) for domestic violence and 44% (1,400 to 2,021) for child abuse from FY2001-11. This increase was primarily driven by the substantial increase in these crimes from their low in FY2006 to their high in FY2011. From FY2006-11, domestic violence increased by 33% (293 to 383) and child abuse increased by 43% (201-287) per capita. However, the low number of incidents in FY2006-08 may reflect a disproportionate number of [surge] Soldiers deployed during this period.

Of those substantiated offenders referred to FAP for either domestic violence or child abuse offenses, an average of 91% (domestic violence) and 93% (child abuse) were enrolled in the program (FY2001-11). However, the percentage of Soldiers who completed the program was significantly less at 60% for domestic violence and 63% for child abuse. Although percentages of enrollment are high with plausible explanations for ~10% who are not enrolled (ETS, separated or deployed), the percentage of Soldiers who failed to complete treatment cannot be so easily explained away. Reasons given for not completing treatment included ETS or separation, gaps in data, or offenders refused treatment. This seems to indicate a gap in program enrollment and

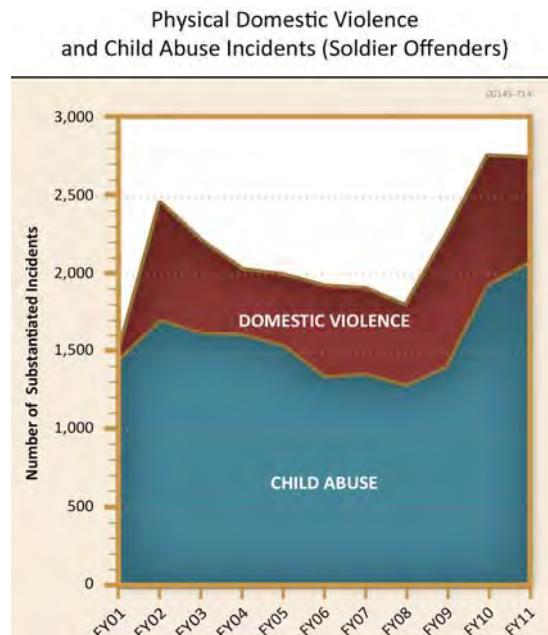


Figure III-46: Domestic Violence and Child Abuse Incidents

¹⁶ Increase in referrals is bracketed from FY2008-11 because of a change in policy and databasing that incorporated all referral numbers (substantiated and unsubstantiated) beginning in FY2008.

Alcohol Involvement in Physical Domestic Violence and Child Abuse Incidents (Soldier Offenders)

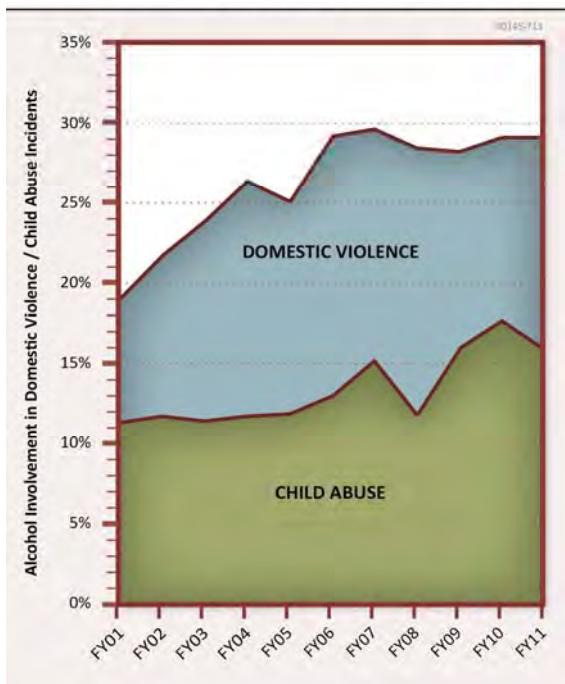


Figure III-47: Alcohol Involvement in Domestic Violence and Child Abuse

treatment policy. Since Soldier separation numbers cannot account for 40% of the offenders not completing the program, it seems that the last two reasons at least partially explain treatment failure. However, given the high recidivism rates and the adverse effects of these crimes on others (spouses and children), the Army must redouble its efforts to ensure full treatment by levying consequences for program failure (e.g., disciplinary or administrative action).

Additionally, alcohol use associated with substantiated domestic violence and child abuse crimes increased over the same periods (figure III-47). Alcohol associated with [physical] domestic violence increased by 54% and with child abuse by 40% from FY2001-11. This may be associated with research in Chapter 2 linking increased alcohol consumption with partner aggression among veterans suffering from combat-related wounds, injuries and illnesses. The Army can expect this problem to continue over the next few years, if not longer.

Recidivism among Soldiers who commit domestic abuse has also trended sharply upward from FY2006-11 as illustrated in the chart at figure III-48. The chart reflects the percentage of recidivism for repeat offenders while residing at a single installation in the same fiscal year (blue), recidivism in the next fiscal year (green) and recidivism after a PCS to a new installation (red) in the same fiscal year. The chart highlights two key issues, the first is the sharp trend upward over the last few years and the second is the perplexing discrepancy between trends regarding recidivism at the same installation in the same fiscal year and at a new installation in the same fiscal year.

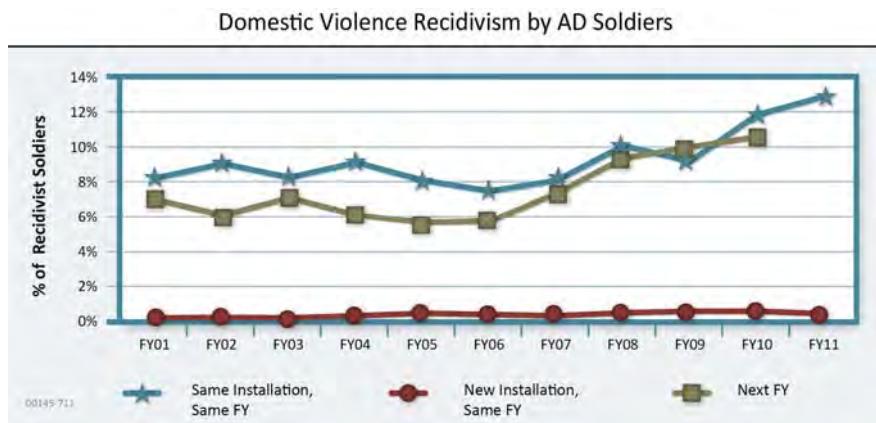


Figure III-48: Domestic Violence Recidivism

This may indicate a gap in surveillance from installation to installation given the consistent increase in recidivism on the same installation for the same fiscal year and next fiscal year. Given the potential gap in the visibility of prior domestic violence, the Army needs to increase information sharing regarding these offenses from installation to installation.

VIGNETTE—CHILD ABUSE

A married 32-year-old PFC (2 years TIS) living in government quarters along with his girlfriend and her two children was charged with first degree murder in 2011. He and his girlfriend intentionally starved her 10-year-old son over a period of months ultimately leading to his death. The child was on a strict diet of rice cakes because he was addicted to sweets and was disciplined whenever he did not comply with the PFC's food intake directives. The nine-year-old daughter appeared malnourished as well; a doctor assessed her in the bottom 5th percentile nationally for her body mass index.

LEARNING POINTS

- ★ From FY2006-11, domestic violence increased by 33% (293 to 383) and child abuse increased by 43% (201-287) per capita. However, the low number of incidents in FY2006-08 may reflect a significant number of Soldiers deployed during this period.
- ★ Alcohol associated with [physical] domestic violence increased by 54% and with child abuse by 40% from FY2001-11. This may be associated with research in Chapter 2 linking increased alcohol consumption with partner aggression among veterans suffering from combat-related wounds, injuries and illnesses.
- ★ The percentage of Soldiers who completed FAP was significantly less than those who were enrolled at 60% for domestic violence and 63% for child abuse.
- ★ Given the high recidivism rates and the adverse effects of these crimes on others (spouses and children), the Army must redouble its efforts to ensure full treatment by levying consequences for program failure (e.g., disciplinary or administrative action).
- ★ Given the potential gap in the visibility of prior domestic violence, the Army needs to increase information sharing regarding these offenses from installation to installation.

4. Army Response to a High-Risk Population



“If we are going to reduce our Army, and all indicators are that we are, we've got to maintain the very best, and those very best have to be counseled and developed and trained — but they also have to be disciplined.”

— LTG Mark Hertling
CG, US Army Europe

Disciplinary accountability includes the full spectrum of administrative and disciplinary tools available to commanders to surveil, detect and respond to acts of misconduct and high-risk behavior in order to repair, rehabilitate, punish, sentence or separate offenders. Discipline is the essence of this professional Army which reflects selfless service to this Nation. It is the hallmark of the all volunteer Force where Soldiers willingly make the choice to serve in accordance with Army values. This choice reflects a personal commitment to honorably serve. Understanding this commitment is important for commanders who must make the distinction between those who unintentionally err and those who intentionally commit misconduct; the distinction between those who can be influenced through counseling / training and those who require disciplinary / administrative action; and the distinction

between those who should be retained and those who must be separated. Decisions made as a result of understanding these distinctions determine the quality of the Army and that of the leaders and Soldiers who serve.

This section covers the essential disciplinary and administrative policy and programs used to respond to crime and misconduct including non-judicial punishment and courts-martial, waivers and flags, separations and commanders reports of disciplinary or administrative action. It highlights current progress in many of these areas which have shown solid improvement over the last few years. It also highlights existing gaps in policy and policy implementation that continue to allow a small population to offend with little or no consequences and continue to serve despite substandard performance. Based on analysis of all available data, the problems which seem to create or sustain these gaps arise from uneven or sporadic policy implementation.

a. Disciplinary Accountability

Given the amount of crime in the Army, not to mention subtle increases in felony crime, one would expect to see an equal increase in courts-martial and Article 15s. On the contrary, judicial and nonjudicial punishment has steadily trended downward from FY2006-11. The chart at figure III-49 depicts Active Component courts-martial, summary courts-martial and Article 15s in rates per 1000 Soldiers. Articles 15 have decreased 31% from 87 to 59 per 1,000 Soldiers during this period. There were 43,813 Articles 15 in FY2006 which decreased to 33,809 in FY2011, which is puzzling given the fact that there were approximately 64,000 more Soldiers and 13% more crime in 2011. The same is true for courts-martial. Courts-martial and summary courts-martial decreased by 28% and 55% in the same period from 2.64 to 1.89 and 2.29 to 1.02 per 1,000 Soldiers, respectively.

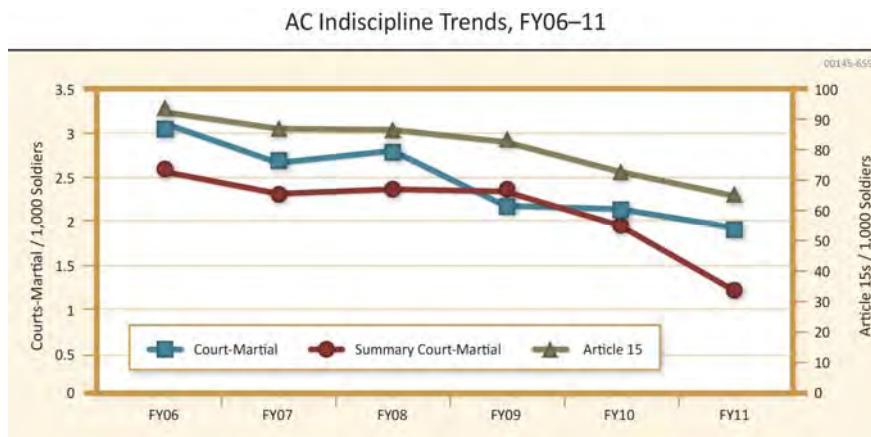


Figure III-49: AC Indiscipline Trends, FY06-11

This analysis is not intended in any way to foster undue command influence into the adjudication process of field commanders. However, this analysis, which reflects a significant sample size and uses population adjusted rates, demonstrates markedly consistent trends that indicate a potentially troubling gap in disciplinary accountability. Even more puzzling is the fact that separations for misconduct have increased by 57% (from 5,606 to 8,815) in the same period. Simply put, disciplinary accountability has reversed its position with administrative separations from high disciplinary actions and low administrative separations to low disciplinary actions and high administrative separations. Although the reasons for this shift are unknown, it begs the question: Are these trends a reflection of OPTEMPO; a reflection of a lack of policy / process awareness; or a reflection of shifting perceptions of criminality?

LEARNING POINTS

★ Articles 15 have decreased 31% from 87 to 59 per 1,000 Soldiers from FY2006-11. There were 10,004 fewer Articles 15 in FY2011 than in FY2006, which is problematic given the fact that there were approximately 64,000 more Soldiers and 13% more crime in FY2011.

b. Administrative Accountability



“Taking care of Soldiers is Commanders’ business and they must act when Soldiers engage in unacceptable behavior. They must distinguish between the Soldier who has made a mistake and those who intentionally demonstrate ongoing risky behavior to themselves and those around them. Commanders’ actions may not be the same for each Soldier -- some respond to counseling / re-training while others respond to disciplinary / administrative actions. Commanders must make the hard call; some of these Soldiers should be retrained (rehabilitated) and others should be separated.”

– MG David Quantock
Provost Marshal General

(1) DA Form 4833

Investigations by law enforcement are a crucial step in ensuring Soldier accountability by informing commanders during adjudication and by providing fair and equitable disposition of criminal offenders throughout the Force. The investigation provides additional evidence to prove or disprove the crime, titles offenders as appropriate, and initiates and documents the commander’s disciplinary or administrative action via the DA Form 4833, *Commander’s Report of Disciplinary or Administrative Action*. The DA Form 4833 is essentially a “court record,” which provides the outcome of disciplinary and administrative proceedings including information on the crime, sentencing, punishment imposed and pertinent referrals (such as drug treatment under ASAP or family counseling under FAP). Most importantly, the DA Form 4833 provides a record regarding offender conduct to be considered in adjudicating subsequent crimes and in informing disciplinary or administrative actions for repeat offenders.

DA Form 4833 reporting is the responsibility of both CID and installation provost marshals who refer these reports to commanders upon completion of every investigation. CID provides reporting oversight for all felony investigations, while provost marshals provide reporting oversight for all misdemeanor investigations. Unfortunately, the misdemeanor—and to a lesser extent the felony—reporting system remain one of the most problematic among disciplinary programs with gaps in reporting noted in every year from FY2006-11. DA Form 4833 reporting compliance for misdemeanors remains at about 60% which means that the Army does not have visibility or accountability of the adjudicated results of misdemeanor crimes in approximately 4 out of 10 cases. The problem stems from a loss in accountability due to a variety of administrative errors, including:

- Gaps in policy which allow some investigations by civilian law enforcement to go unreported / recorded via DA Form 4833, which results in the potential loss of visibility and accountability for some crimes;

- Installation law enforcement failing to refer DA Forms 4833 to commanders to record adjudication of offenses titled in the investigation;
- Commanders failing to complete, submit or accurately record all disciplinary, administrative and program referrals as required by policy;
- Installation law enforcement not conducting a quality review of DA Forms 4833 returned by commanders to ensure report completeness and accuracy;
- Installation law enforcement failing to enroll DA Forms 4833 returned by commanders into the Centralized Operations Police Suite (COPS) database.

DA Form 4833 reporting for felony offenses is far more effective with compliance rates averaging 95% from FY2001-09 (figure III-50). Compliance rates for FY2010-11 were not included in this average because many of these investigations are either on-going or pending adjudication. Compliance rates for these years are expected to be similar to previous years. Although reporting of felony adjudication is a good news story, additional refinement in DA Form 4833 reporting with respect to completeness and accuracy is still required. However, the efficacy of this DA Form 4833 system proves that policy and implementation can work effectively.

Fiscal Year	Eligible	Not Referred	Referred	Pending	Overdue	Completed	Percent Completed
FY01	10045	367	9678	0	0	9678	96%
FY02	11415	515	10900	0	0	10900	95%
FY03	9689	645	9044	0	4	9040	93%
FY04	7140	465	6675	0	5	6670	93%
FY05	7852	166	7686	1	13	7672	98%
FY06	8214	116	8098	1	113	7984	97%
FY07	6664	55	6609	1	171	6437	97%
FY08	7420	100	7320	17	503	6800	92%
FY09	6641	74	6567	4	281	6282	95%
FY10	5519	134	5385	23	717	4645	84%
FY11	6803	794	6009	910	1819	3280	48%
FY01-11 Total	87,402	3,431	83,971	957	3,626	79,388	91%

Figure III-50: 4833 Referral Status (CID Data Only)

As a caveat, however, reporting compliance does not reflect whether or not adjudication and disciplinary / administrative actions taken were thorough or appropriate. As highlighted under Shifting Perceptions of Criminality, there are numerous examples of criminal activity with no action or inappropriate action taken. For example, of a random sample of 227 cases of marijuana use (first time offenders) referred to commanders by law enforcement, DA Form 4833 data show that: 81 Soldiers received Articles 15 (at varying levels) with 18 separated from the Army; 63 received administrative actions (e.g., written admonishment); 47 were returned with no action taken by the commander and 36 had no record of adjudication (4833 was never returned). Of the 47 cases returned with no action taken (e.g., administrative or disciplinary), 19 Soldiers went on to offend again.

VIGNETTE—LOSS OF SURVEILLANCE AND A THREAT TO READINESS

In February 2007, a 25-year-old SGT with one deployment was investigated for the rape of another Soldier (off-post). He was tried in civilian court, pled guilty to Harassment in the 2nd Degree and was sentenced to a one year conditional discharge. His unit took no further action. In February 2008, the SGT was arrested for DUI, plead guilty to DUI in civilian court and paid a \$300 fine. His unit took no further action. He was arrested in May 2008 for disorderly conduct (off-post assault) and failed to notify the court of his pending deployment. As a result, he was arrested on a warrant in May 2009 for failing to appear. His unit issued him a written reprimand. In August 2009, the SGT was apprehended for the illicit use of prescription medication (Ativan). The DA Form 4833 reflects no action was taken. That same month, he was accused of raping two women while both were incapacitated from alcohol and prescription medication. Both offenses were founded; there is no court record as the DA Form 4833 has been overdue since August 2010. The SGT was accused of rape, cruelty / maltreatment of a subordinate and failure to obey an order in October 2009. Although the rape was later unfounded, the other two offenses were founded. All other offenses were founded. In February 2011, the SGT was arrested off-post for DUI and aggravated unlicensed operation of a motor vehicle.

DA Forms 4833 for the latter two crimes indicate the SGT received a Chapter 10 – In Lieu of Court Martial – and received an Other Than Honorable Discharge.

The SGT was assigned to the same battalion during the conduct of the above seven crime events spanning four years.

LEARNING POINTS

- ★ The DA Form 4833 is essentially a “court record,” which provides the outcome of disciplinary and administrative proceedings including information on the crime, sentencing, punishment imposed and pertinent health referrals.
- ★ Gaps in the DA Form 4833 misdemeanor reporting system remain one of the most problematic among disciplinary programs, with gaps in reporting noted in every year from FY2006-11.
- ★ DA Form 4833 reporting for felony offenses is far more effective with compliance rates averaging 95% from FY2001-09.

(2) Accession Waivers

Accession waivers help the Army to meet its recruiting goals while providing deserving young Americans an opportunity to serve in the military. The vast preponderance of these recruits go on to serve professionally for a tour or even a full career. There is a small amount of risk accepted by the Army, however, as evident through increased rates of misconduct among waivered recruits when compared to the non-waivered cohort population. When comparing these two populations, research found Soldiers with conduct waivers had a lesser probability of attriting in their first year but a 13% higher probability to attrit by the end of their first term of enlistment. Those with a drug waiver, moreover, had a 38% greater probability of attriting in the same period.²⁸⁵

The chart at figure III-51 provides a picture of AC drug / alcohol and all conduct waivers (felony and misdemeanor) from FY2004-11. It depicts a bell curve of accession waivers which peaked in FY2007-08 before rapidly trailing off to its lowest level in

FY2011. Among the total number of waivers, those for drug and alcohol peaked in FY2007 at 1,307 with a significant drop in FY2009 to 337 before zeroing out in FY2010-11 (based on a change in Army policy). Other major misconduct waivers (felony) similarly peaked in FY2007 at 1,430 with a significant drop in FY2011 to 189 waivers. Analysis of drug and alcohol waivers for Soldiers testing positive for illicit drug use at IET from FY2004-11 demonstrated a remarkable resemblance to the waiver “bell curve.” Drug positive rates climbed steadily upward from .79% (per 100 Soldiers) in FY2004 to 1.46% in FY2006, 1.31% in FY2007, before precipitously dropping to .35% in FY2011 (no waivers). Additionally, FY2006-08 were the lowest tested years despite a significant increase in accessions in the same period.

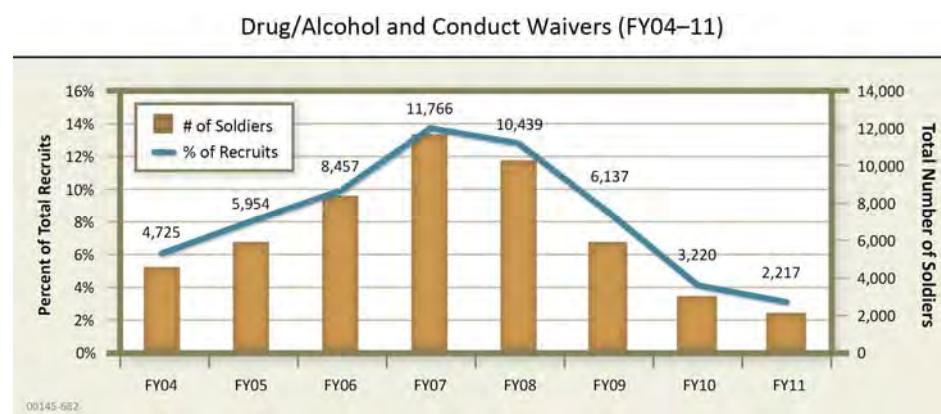


Figure III-51: Drug / Alcohol and Conduct Accession Waivers, FY04-11

VIGNETTE—PRE-SERVICE SCREENING

In January 2009, a 42-year-old married SSG with medical and marital problems was found hanging in his barracks room. The SSG was in marital counseling and was upset that his wife would not attend with him. He was facing a divorce and \$1,000 / month in child support. The SSG was also being seen for medication management. Medical personnel indicated the SSG had demonstrated numerous “cries for attention.” In September 2008, he was involved in a verbal dispute with his wife which prompted him to attempt suicide by ingesting an unknown amount of prescription medication.

A review of this NCO’s service record revealed he served in the Navy from 1985 to 1988 before being medically chaptered for a personality disorder. In 1998, the SSG enlisted in the RC Army with a waiver for the diagnosed personality disorder. In 2002, he transitioned to the AC.

Additional analysis at figure III-52 revealed that the waivered population (drug / alcohol and misconduct) had a significantly higher rate of criminal offenses per capita than the non-waivered population while serving on active duty from FY2001-11. The waivered population (as a cohort) committed over twice as many criminal offenses when compared against the non-waivered population with percentages ranging between 29-36% as compared to 15%. Those with drug waivers were 6 times more likely to commit a drug offense than the non-waivered cohort with 20% committing drug offenses compared to 3% of the remaining population. Additionally the waivered population was 2-3 times more likely to commit specific crimes while serving, including felony offenses of aggravated assault, failure to obey, and desertion; and misdemeanor offenses of AWOL, DUI, assault and battery and family abuse.

Crime Type and Category	Unique Subjects w/ Conduct Waiver, FY01-11	% of Soldiers w/ Conduct Waiver	Unique Subjects w/ Drug Waiver, FY01-11	% of Soldiers w/ Drug Waiver	Unique Subjects w/ No Waiver, FY01-11	% of Soldiers w/ No Waiver
Violent Felony						
Homicide	58	0.1%	14	0.1%	486	0.0%
Sex Crimes	266	0.5%	48	0.4%	3,329	0.3%
Kidnapping	18	0.0%	4	0.0%	154	0.0%
Robbery	32	0.1%	9	0.1%	264	0.0%
Aggravated Assault	499	0.9%	92	0.9%	3,725	0.3%
Child Pornography	47	0.1%	5	0.0%	781	0.1%
Non-Violent Felony						
Drug Crimes	5,475	9.5%	2,102	19.6%	36,929	3.2%
Failure to Obey General Order	1,640	2.9%	367	3.4%	17,406	1.5%
Desertion	1,251	2.2%	272	2.5%	12,179	1.1%
Larceny	667	1.2%	143	1.3%	7,772	0.7%
Other Sex Crimes	256	0.4%	42	0.4%	2,902	0.3%
Drunk Driving with Personal Injury	48	0.1%	14	0.1%	309	0.0%
Other Non-Violent Felonies	2,548	4.4%	587	5.5%	25,833	2.3%
Misdemeanor						
Traffic Violations	4,940	8.6%	876	8.2%	62,343	5.5%
Assault and Battery	2,505	4.4%	427	4.0%	20,881	1.8%
AWOL	1,910	3.3%	385	3.6%	18,894	1.7%
Drunk Driving without Personal Injury	2,762	4.8%	491	4.6%	17,585	1.5%
Drunk and Disorderly	1,706	3.0%	296	2.8%	12,416	1.1%
Family Abuse	955	1.7%	169	1.6%	8,572	0.8%
Other Misdemeanors	2,578	4.5%	532	5.0%	24,990	2.2%
Total Unique Subjects	16,551	28.8%	3,824	35.7%	168,815	14.8%
Total Unique Soldiers, FY01-10 Accessions	57,475	Conduct Waiver	Drug Waiver	No Waiver		
			10,699	1,137,018		

Figure III-52: Crime Comparison of Soldiers with Conduct and Drug Waivers vs. No Waivers

The analysis of the waivered recruit population supports changes in accession policy which significantly reduced accession waivers from FY2009-11. By FY2009 the Army reversed its policy for drug waivers which had allowed recruits who tested positive at the Military Entrance Processing Station (MEPS) to return after 45 days for re-testing. It also suspended waivers for recruits convicted of drug possession, use or drug paraphernalia. However, it did not prevent Army entrance for recruits who admitted to drug use. Also it is not known if eliminating convictions for drug offenses will soften adjudication of these offenses to allow recruits to enter the Army under the old adage of “serve (Army) or serve (time).” Regardless, changes in policy reflect the lesson that if the Army controlled its intake (vetted recruits), it could significantly reduce the effects of crime on Force discipline and readiness. However, should the Army require waivers to meet urgent troop demands it may want to heed advice given in a published study from January 2011 where researchers concluded “We suggest providing commanders with waiver information...that is easy to understand...would allow commanders to give waivered recruits extra guidance and leadership.”²⁸⁶

There are also fiscal benefits to improving vetting of recruits with prior histories of misconduct. The FY2010 USAREC cost per accessions for AC Soldiers was \$22,898, but increased to \$73,000 by the time they reach their first duty station (Including Basic Training and AIT).²⁸⁷ These figures represent the FY2010 cost for recruiting and training any Soldier. Given that Soldiers who received a misconduct waiver were twice as likely to commit an offense when compared to the baseline population, it follows reason that this would place them at twice the odds for separation. This means that Soldiers among the waivered population would cost twice as much or up to \$146,000 per Soldier accessed when compared to the base population.

LEARNING POINTS

- ★ Analysis of drug and alcohol waivers for Soldiers testing positive for illicit drug use at IET from FY2004-11 demonstrated a remarkable resemblance to accession waiver patterns.

- ➊ The waivered population (as a cohort) committed over twice as many criminal offenses when compared against the non-waived population with percentages ranging between 29-36% as compared to 15%.
- ➋ Changes in policy reflect the lesson that if the Army controlled its intake (vetted recruits), it could significantly reduce the effects of crime on discipline and readiness.
- ➌ The Army has changed its policy to reduce misconduct accession waivers which, if sustained, will continue to decrease incidents of criminal misconduct.

(3) Flags

The Army Inspector General conducted an inspection of the Army's process of suspension of favorable actions (Flags) which provided a thorough look at an effective administrative tool for improving unit and Soldier discipline. The report acknowledged findings in the Red Book that the Army's professional development priorities and OPTEMPO had eroded technical skills, communication skills and experiential knowledge to lead / manage effectively in the garrison environment. This acknowledgement underpinned their findings that many leaders did not have a good understanding of how to use flag actions to increase surveillance of Soldiers potentially undergoing disciplinary or administrative action and to suspend favorable action pending an inquiry and final adjudication. Their findings are generally summarized in five key points:²⁸⁸

- A lack of training at all levels erodes technical skills and knowledge with respect to execution of flagging actions;
- Company-level teams are not effective in flagging Soldiers under investigation. The team found that commanders at all levels are challenged with imposing flags on Soldiers under investigation because they do not know when to impose a flag or are taking a "wait and see" approach before imposing flags;
- Transferable flags and supporting documents are not being transferred from losing units to gaining units;
- Army policy mandates initiation of a flagging action when a formal or informal investigation is initiated on a Soldier by military or civilian authorities;
- Poor flag management is detrimental to the Army's morale and negatively impacts our collective ability to manage the Force by making timely and informed decisions.

The use of an administrative identification system (e.g., HQDA centralized flag) would increase Army surveillance of Soldiers pending investigation / inquiry and adjudication for a second felony offense (as a multiple felony offender). This would not lessen the broad discretion of command teams who are responsible for the health and discipline of their units. They would retain exclusive authority for adjudicating the offense but would be required to submit justification for lifting the HQDA flag. The premise of this policy is no different than policy that allows senior commanders to withhold certain disciplinary and administrative actions at their respective levels. It would simply act to give HQDA visibility of multiple felony offenders—regardless of the crime—to ensure that policy continues to provide a broad scope of influence over emerging crime trends. Also, it would guarantee the eventual attrition of multiple felony offenders (through elimination of service) who potentially slip through any number of gaps in disciplinary and administrative systems.

This initiative could be implemented using current systems already in place. Close coordination between CID and G-1 (HRC), for example, could provide requisite information to trigger an enduring

administrative action (e.g., centralized flag) to identify a second time felony offender pending adjudication of the second offense. For instance, CID could provide information to G-1 (HRC) regarding the initiation of an investigation on a Soldier who has allegedly committed a second felony-level offense when the first offense was adversely adjudicated (as reflected on the DA Form 4833). If the Soldier is acquitted during adjudication of the second offense, the Soldier's commander would submit appropriate documentation to remove the administrative action.

LEARNING POINTS

- ★ Use of flags is an effective tool to suspend favorable actions (e.g., reenlistment) for Soldiers pending investigation and adjudication.
- ★ There is no central HQDA flag to increase senior leader awareness of multiple felony offenders.

(4) Separations

One of the most significant areas of improvement in disciplinary and administrative actions has been achieved through the significant increase in Chapter 14 separations for Soldier misconduct. Figure III-53 illustrates this increase in separations from a low of 11,705 in FY2006 to 17,510 in FY2011. This represents the second part of a policy strategy to first reduce accession waivers and second to increase discharge rates for criminal offenders. The results of this strategy can be illustrated by comparing this figure (separations) with figure III-51 (accession waivers). As the Army dramatically reduced its accession waivers by 81% from FY2007-11, it increased its separations by 50% from FY2006-11. This ultimately accounted for a reduction of almost 50,000 Soldiers (who committed misconduct) who could have entered or been retained in the Force under conditions and standards set in FY2006-07. Changes in policy and policy implementation made an impactful difference in discipline across the Force.

A literature review of Soldier attitudes towards military service obligations

provides another persuasive point for chaptering Soldiers who commit drug offenses, which represents the largest aggregate number of felony offenders year over year. It revealed that "Soldiers taking drugs have more critical attitudes toward military service obligation and to a greater degree accept the opinion that it is a waste of time for them. Soldiers taking drugs have worse results in general and professional military training."²⁸⁹

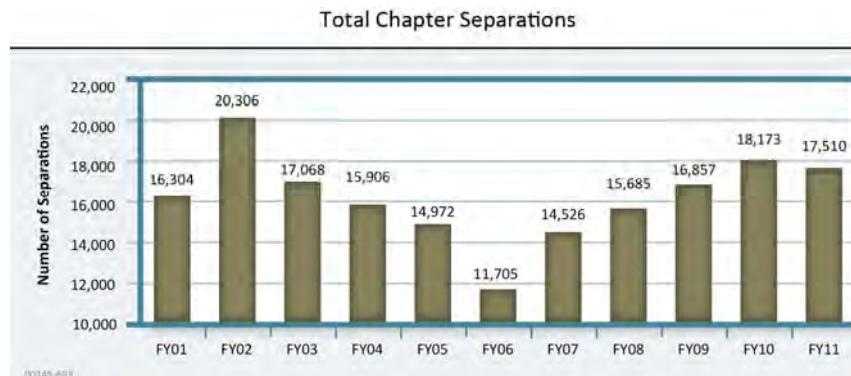


Figure III-53: Total Chapter Separations¹⁷

¹⁷ This data consists of the following chapters: Chapter 5-13 (Personality Disorder), Chapter 5-17 (Physical/Mental Condition), Chapter 9 (Drug/Alcohol Rehab Failure), Chapter 10 (in lieu of Trial by Court-Martial), Chapter 11 (Entry Level Separation), Chapter 13 (Unsatisfactory Performance) and Chapter 14 (Misconduct).

LEARNING POINTS

- ★ One of the most significant areas of improvement in disciplinary and administrative actions has been achieved through the significant increase in Chapter 14 separations for Soldier misconduct.
- ★ This ultimately accounted for a reduction of almost 50,000 Soldiers (who committed misconduct) who could have entered or been retained in the Force under conditions and standards set in FY2006-07.

The data presented in this chapter clearly indicate that the Army continues to be challenged by the effects of high-risk behavior that, if left unchecked, will continue to impact Army readiness. While these disciplinary indicators may not be seen in all formations, this section presents Army wide data to inform commanders of the seriousness of the effects of high-risk Soldiers on the Force and provides compelling evidence that support the two overarching conclusions: (1) there is still much work to do in implementing existing administrative and disciplinary policy and programs, and (2) the work of diligent leaders is already having an impact on reversing previous trends. In short, while daunting, the work ahead is doable.

IV – Synthesis of Army Surveillance, Detection and Response to At-Risk and High-Risk Populations

The previous chapters of this report inform readers of the current status of the health and discipline of the Force after more than a decade of war. The message is evident: there are challenging times ahead; and, the key to a successful transition is clear strategic direction from the Army's most senior leaders, policy synchronization at HQDA level and consistent policy implementation across the Force.

Chapter I provided context for subsequent discussions specific to the topic of the report. With the majority of troops returning from combat operations, the Army is preparing to transition from a wartime Army to one predominantly training and preparing for future contingencies. This will be a time of change and challenge further complicated by planned reductions to end strength, severe budgetary constraints, the return and reset of equipment, and the rehabilitation and reintegration of personnel back into units, Families and communities.

Chapter II took an in-depth look at the health of Soldiers and Family members after a decade of war. The sizeable population of Soldiers and veterans requiring significant care and support in coming years presents a unique set of challenges with respect to surveillance, detection and response mechanisms, fitness for duty determination, and demand on the military's and VA's healthcare and disability evaluation systems.

Chapter III focused on the discipline of the Force with respect to crime and other high-risk behaviors. It assessed the effectiveness of the Army's surveillance, detection and response efforts to mitigate the effects of crime and to hold offenders accountable; whether through disciplinary or administrative action. It highlighted improvements in policy and policy implementation over the last few years, while acknowledging the necessity for further improvement to reduce existing gaps.

This chapter ties these two distinct, yet interdependent issues—namely the health and discipline of the Force—together, effectively emphasizing the need to address both in tandem. It provides a road map for Army leaders (at all levels) to address the health and discipline of the Force ahead of the strategic reset. It emphasizes the importance of strategic policy; highlights a strategy to improve surveillance, detection and response to health and disciplinary related issues; and provides specific recommendations for policy implementation. Simply stated, this chapter lays out the way ahead; what must be done from HQDA down to the unit commander level to build upon the progress to date and successfully complete the strategic reset, while ensuring a ready and capable Army for the future—2020 and beyond.

1. Impact of Health and Discipline on Readiness

The strategic reset of the Army will require consistent and uniform health and disciplinary policy formulation, promulgation and implementation. More so than any other single factor, the health and discipline of individual Soldiers determines the readiness of our Army. Over the past decade, the high number of non-deployables, due to health and disciplinary issues, has affected Army readiness. The gravity of many of the wounds, injuries and illnesses incurred on today's battlefields, the associated complex treatments and duration of recovery and rehabilitation, all have contributed to the growing backlog in the healthcare and disability evaluation systems. This loss in readiness is further eroded by

inconsistent disciplinary accountability (adjudication and separation) of Soldiers whose criminal and high-risk behavior compromises the readiness of themselves and others. The average length of time required to either separate or return Soldiers to available status is significant, often diverting too much of our leaders' time and attention away from available Soldiers and mission-related activities.

As demonstrated in figure IV-1, the shortage of available personnel is likely to worsen over the next few years as further reductions are made to end strength. If the non-deployable rate continues to increase while the Army simultaneously off-ramps the 22,000 Soldiers brought on in FY2009 (by means of the Temporary End-Strength Increase), the result will be a projected mission shortfall of approximately 13,000 Soldiers by mid-FY2013.

When combined with the planned unavailable population (e.g., schools, PCS), the number of Soldiers available for deployment or reassignment will likely be reduced by as many as 60,000. This will have a domino effect on unit readiness. The Army may be required to resort to just-in-time manning for deploying units. This could result in squads being undermanned and / or

uncertified for missions in support of both contingency and home station missions. Additionally, the increased demand will impede the Army's ability to effectively increase BOG:Dwell ratios.¹⁸ This will translate to less time between deployments, making it increasingly difficult for Soldiers to rest, recuperate and recover fully.

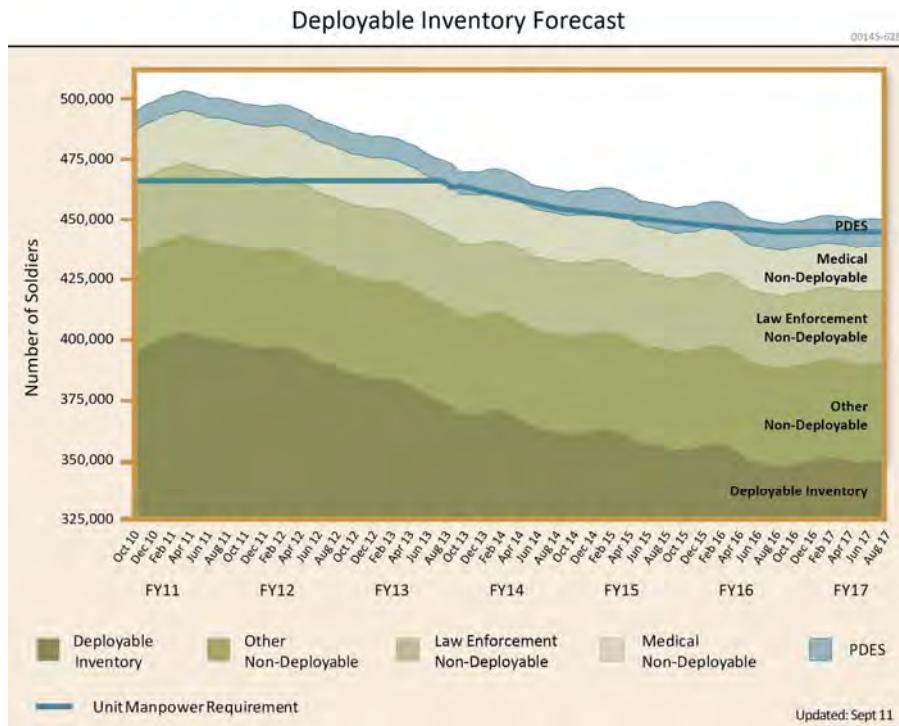


Figure IV-1: US Army's Deployable Inventory

Inconsistencies in both published policy and policy adherence confirm the need for clear strategic direction with respect to the health and discipline of the Force. Existing gaps have contributed to many of the problems addressed in this report as leaders sometimes overlook misconduct and disciplinary issues and as Soldiers frequently ignore their own health concerns. Commanders and subordinate leaders must be given definitive guidance regarding health and disciplinary actions and execute accordingly. This will ensure synchronization of subordinate functions specifically designed to sustain the readiness of the Force (e.g., crime reporting, separations / discharges, accessions, family advocacy). It will require leaders to make difficult decisions in coming days based on Soldier performance and readiness in accordance with regulatory guidance. And, making the right decisions (on behalf of the Army, Soldiers and Families) requires knowledge of policy, complying with its intent and—equally important—understanding the variety of issues associated with Soldier health and discipline.

¹⁸ Per DCS, G-1 presentation (slide) dated 11 September 2011.

2. Health and Discipline Policy

a. Grand Policy Guidance (Health and Discipline)

Since the establishment of the HP/RR/SP Task Force and Council in 2009 and the publication of the *Red Book*, the Army has made tremendous progress in its efforts to identify and reduce gaps in coverage, while eliminating redundancies with respect to existing policy and processes. Now more than ever, the Army must continue its progress within the context of the strategic reset and while recognizing the need to respond aptly on behalf of Soldiers whose health or misconduct puts them at increased risk. To date, many of the recommendations provided by the TF have been successfully completed. However, shortfalls remain, primarily with respect to the formulation and implementation of policy at appropriate levels.

As illustrated in figure IV-2, three policy imperatives enable effective surveillance, detection and response of the Army's at-risk and high-risk populations: (1) clear senior leader intent in key areas of grand policy guidance; (2) synchronized supporting policies across Army proponents to provide a unified interdisciplinary approach; and, (3) standard implementation across commands at all levels of the field Army. Ideally, grand policy guidance conveys senior leader intent, which informs the development of subordinate policies across an array of regulations that in turn directs standard implementation Army-wide. For example, once the Army determines its grand policy guidance for Soldier "fitness for duty" or "discipline and administrative actions," that policy will synchronize a multidisciplinary approach—across OTSG, ACSIM, OPMG, OTJAG and G-1—for the uniformed implementation of supporting policies, programs and resources. Consequently, in a single policy stroke the Army can improve both the health and discipline of the Force.

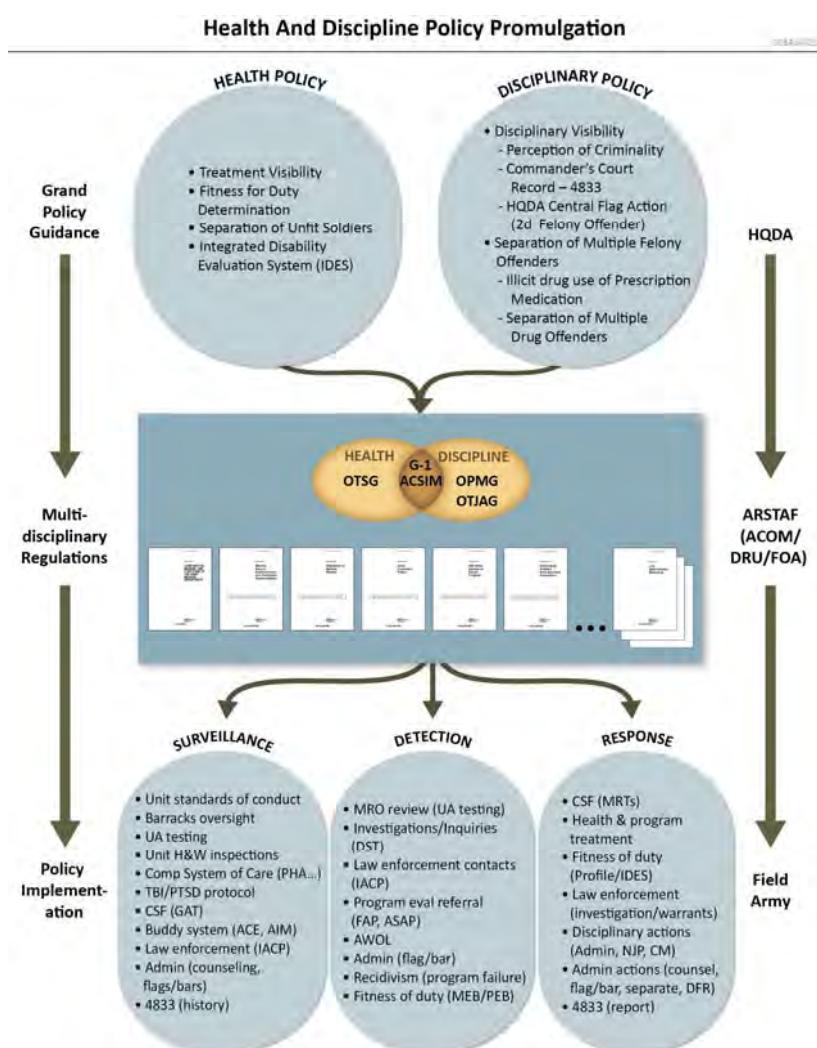


Figure IV-2: Health and Disciplinary Policy Promulgation Model

A lack of clear grand policy guidance results in conflicting Army regulations (across the same Army proponents) and, ultimately, impacts subsequent interpretation and implementation across the Force.

A single inconsistency in policy intent will create gaps in regulations that will be interpreted in a variety of different ways at command levels. For example, a failure to develop grand policy guidance regarding illicit drug use of unauthorized prescription medications has created a lag in implementing related policy published by MEDCOM in February 2011. This guidance must address the question: Is it HQDA's intent to adversely adjudicate prescription drug use beyond its expiration as felony illicit drug use, even in an environment of war and post-war proliferation and reliance on pain narcotics? This question forms the basis of a strategic Army dilemma, which unless unequivocally addressed, is transferred to the field Army as a commander's dilemma. If not clearly addressed, it will result in the uneven application of drug policy with respect to drug-related adjudication and Soldier disposition across the Force. In other words, some Soldiers may not be adjudicated for illicit use of prescription medication, others may be adjudicated only, and yet others may be adjudicated and separated.

b. Promulgation of Policy (Health and Discipline)

The following subparagraphs provide five key recommendations for clarifying grand policy guidance regarding Soldier health and discipline including: (1) treatment visibility, (2) fitness for duty determination, (3) separation of unfit Soldiers, (4) disciplinary visibility, and (5) separation of multiple felony offenders. Each of these recommendations highlight policy (or a portion of policy) that must be addressed at HQDA to ensure a synchronized multidisciplinary approach that will be uniformly interpreted and implemented throughout the Army. Collectively, they comprise the learning points regarding health and disciplinary surveillance, detection and response highlighted in Chapters II and III and the Army's implementation strategy in the next two sections of this chapter.

(1) Treatment Visibility

Among the most effective methods for treating behavioral health conditions and substance abuse issues in view of the long-standing stigma have been confidential counseling / treatment programs such as CATEP, TRIAP or Military OneSource. These confidential programs enable Soldiers to receive the help they need without chain of command notification. This alleviates the widespread concern that seeking help for these types of conditions may adversely affect an individual's career or others' perception of the individual. However, feedback from commanders indicates a general disagreement with the confidentiality aspect of these programs, arguing that they represent an important partner in the health triad, responsible for facilitating Soldier treatment (e.g., scheduling appointments, prioritizing treatment during mission and training cycles). The most frequent counter argument made by advocates of these confidential programs is that commanders are unaware of these Soldiers' need for treatment (otherwise they would have referred them to ASAP). As such, it is better that they receive some treatment, even if commanders are unaware, than none at all (see Chapter II, section 2.d.(4)).

RECOMMENDATIONS

- ★ Continue to provide confidential treatment options for Soldiers who have not had a high-risk incident or who are not undergoing disciplinary or administrative action associated with a high-risk incident. Monitor and assess the benefits of confidential programs (e.g., stigma reduction, medical evaluation, information regarding addictions, and treatment) against the risk associated with not informing the chain of command to determine future programming decisions.
- ★ Identify clear triggers for initiating a "warm hand-off" into medical treatment programs and for command notification.

(2) Fitness for Duty Determination and Disability Evaluation

Estimates on process length for retirement and disability determination range from 373-400 days with a backlog of ~18,000 undergoing the process at any given time. The number of Soldiers requiring retirement and disability determination has increased 169% (6,948-18,671) since January 2008 and is expected to increase in the near term. The Integrated Disability Evaluation System, which integrates military and VA systems to streamline Soldier processing, has been implemented. Continued improvements would be to (1) develop an interoperable IT system between DoD and VA to facilitate Soldier transition between departments; (2) increase the number of healthcare providers available to complete the NARSUM, which informs the PEB evaluation; and (3) increase tele-health network to include other externally contracted healthcare providers. Discussions within DoD and VA should continue regarding whether the disability evaluation process should be incorporated into a single system (see Chapter II, section 3.e.).

RECOMMENDATIONS

- ★ Implement the recommendations outlined above to continue to improve the disability evaluation system.

(3) Separation of Soldiers Medically Unfit for Duty

Currently there are ~15,000 Soldiers (AC) undergoing the MEB / PEB process at any given time with an additional ~15,000 Soldiers who have completed the process with a P3/P4 profile who are still serving. As the war continues and / or as Soldiers with health conditions are identified, this population will likely grow significantly (see Chapter II, section 3.e.). Decisions made regarding a Soldier's continued service in the military must be based on individual performance and readiness as benched against Army standards. Not all injuries are the same, nor do they impact every individual in the same way. For example, a Soldier with PTS who can perform to mission and training standards should be allowed to serve the same as any other Soldier without PTS. In contrast, an individual suffering from moderate TBI and whose cognitive impairment adversely affects mission and training performance should be evaluated for disability and medically separated or retired.

RECOMMENDATIONS

- ★ Separating Soldiers considered not medically fit for duty should be based on the Soldier's individual performance and readiness in accordance with mission and training standards (medical and physical evaluation boards).

(4) Disciplinary Visibility

Maintaining visibility of criminal and high-risk behavior at all levels of command is critical to sustaining the good order and discipline of the Force. Discipline in the ranks requires active leader engagement, clearly defined standards of conduct, and prompt, appropriate administrative and disciplinary action. Senior leaders must promote a common understanding of criminal and high-risk behavior and its impact on others. They must clearly delineate between what is acceptable and unacceptable. They must make the distinction between those who unintentionally err and those who intentionally commit misconduct; the distinction between those who can be influenced through counseling / training and those who require disciplinary / administrative action; and the distinction between those who should be retained and those who must be separated. Decisions made as a result

of understanding these distinctions determine the quality of the Army and that of the leaders and Soldiers who serve.

(a) Perception of Criminality

The rise in crime in contrast to the decline in disciplinary action (e.g., court martial, summary court martial, Article 15), retention of multiple felony offenders and the deliberate change in terms of reference regarding criminal misconduct all point to a softening in the perception of criminality (see Chapter III, section 2.a.). Subtle changes in policy language (e.g., removing the term “criminal” from “serious criminal misconduct”), which may inadvertently shift leader perception of criminality, will not change the nature of the criminal act or alter its impact on victims, good order and discipline, and unit readiness.

Army policy (MCM, UCMJ and AR 195-2) clearly establishes thresholds for criminality, elements of crime, punishment and investigative authority. These thresholds are time-tested; they recognize the need for measured disciplinary and administrative action appropriate to the level of criminal misconduct. Other trends covered throughout this report including an increase in violent crime, declining rates of courts-martial and Articles 15, and declining use of flags and bars may be telling. The question is: are these trends a reflection of OPTEMPO; a reflection of a lack of policy / process awareness; or a reflection of shifting perceptions of criminality?

As discussed in Chapter III, the shifting perception of criminality can be illustrated by the inconsistency in the adjudication and disposition of first time marijuana users from FY2006-11, but this is by no means the only example. Of a random sample of 227 cases of marijuana use, 81 received Articles 15 (18 separated from service), 63 received written or verbal admonishment, 47 received no disciplinary or administrative action and 36 had no recorded disciplinary or administrative action.

RECOMMENDATIONS

- Policy governing all areas of the human domain (e.g., personnel, law enforcement, family advocacy and legal actions) should consistently define misconduct based on its criminal nature, whether felony or misdemeanor. Senior commanders should reaffirm standards of conduct and monitor disciplinary and administrative trends across subordinate commands.

(b) Commander's Court Record (DA Form 4833)

Commanders are required to complete the *Commander's Report of Disciplinary or Administrative Action* (DA Form 4833) to document the adjudication of criminal misconduct. This form represents the Army's only record of Soldier disciplinary and administrative action. The DA Form 4833 is essentially a commander's “court record,” which provides the outcome of disciplinary and administrative proceedings including information on crime, sentencing, punishment imposed and pertinent referrals (e.g., ASAP). Most importantly, the DA Form 4833 provides a record regarding offender conduct to be considered in adjudicating subsequent crimes and informing disciplinary or administrative actions for repeat offenders. Although the Army does extremely well in documenting felony-level DA Forms 4833, approximately 40% of misdemeanor-level DA Forms 4833 are neither referred by law enforcement nor returned by the commander. This remains one of the most critical gaps in disciplinary action across the Force. Without full documentation commanders will not have a 360° view of Soldier misconduct or referral during subsequent adjudication of repeat offenders. This loss of visibility allows Soldiers to repeatedly slip through gaps as discussed in Chapter III, section 4.b.(4).

RECOMMENDATIONS

- ★ HQDA revise policy requiring CID to complete a DA Form 4833 for all off-post felony-level offenses.
- ★ Installation Provost Marshals must refer all misdemeanor criminal offenses (including DD Form 1805 traffic citations) to commanders via DA Forms 4833.
- ★ Installation Provost Marshals must conduct a quality review of DA Forms 4833 returned by commanders to ensure report completeness and accuracy.
- ★ Installation Provost Marshals must enroll DA Forms 4833 returned by commanders into the Centralized Operations Police Suite (COPS) database.
- ★ Senior Commanders should monitor and track DA Forms 4833 for 100% compliance as a part of their command surveillance systems (e.g., Command and Staff Call, USR, Organizational Inspection Program).

(c) Identification of Second-Time Felony Offenders

As addressed in Chapter III, section 4.b.3, many leaders do not have a good understanding of how to use administrative flags to increase surveillance of Soldiers potentially undergoing disciplinary or administrative action. Often they do not know when to impose a flag or are taking a “wait and see” approach before imposing flags. As a result, a substantial number of Soldiers may slip through gaps during investigation and adjudication of criminal misconduct.

At a minimum, the Army should impose a centralized flag at HQDA level for Soldiers pending investigation / inquiry and adjudication of a second felony offense (as a multiple felony offender). Commanders would retain exclusive authority for adjudicating the offense, but would be required to submit justification for lifting the HQDA flag. This policy would simply act to give HQDA visibility of multiple felony offenders; while guaranteeing the eventual attrition of those offenders (through separation) who may potentially slip through any number of gaps in disciplinary and administrative systems.

RECOMMENDATIONS

- ★ Senior Commanders should monitor and track administrative flag actions as a part of their command surveillance systems (e.g., Command and Staff Call, USR, Organizational Inspection Program).
- ★ The Army should consider the establishment of an enduring HQDA level identifier (e.g., administrative flag) for Soldiers pending investigation / inquiry and adjudication of a second felony offense.

(5) Separation of Multiple Felony Offenders

Although the Army has significantly reduced the number of multiple felony offenders on active duty, it had 4,877 still serving in FY2011. This clearly indicates a gap in administrative separations, which by all measures, would be appropriate as part of the disposition of a second time felony offender. Although the Army has policy regarding processing the separation of drug offenders, it lacks policy for processing the separation of Soldiers committing other felony offenses as highlighted in Chapter III, section 3.c.(2). Gaps in policy and policy implementation that allow the retention of multiple felony

offenders are particularly troubling given the impact they have on victims and unit readiness over time. The adverse disciplinary and administrative measures appropriately taken against the majority of multiple felony offenders have a positive impact on overall discipline. They not only remove Soldiers exhibiting criminal and high-risk behavior from the Army but they also reduce the transmission of high-risk behavior across units and communities, and when their service is appropriately characterized, prevent their reentry or transition to the RC. For example, there is a familiar transmission of drug use to drug distribution that can increase the illicit use of drugs among Soldiers in the barracks.

(a) Multiple Drug Offenders

AR 600-85, *The Army Substance Abuse Program*, clearly states that commanders *will* initiate a chapter in the event a Soldier tests positive for drug use; and, the commander *will* process the chapter in the event of a second positive urinalysis (see Chapter II, section 2.d(4)). Additionally, AR 635-200, *Active Duty Enlisted Administrative Separations*, highlights that abuse of illegal drugs is serious misconduct but is less directive with respect to separation. Nevertheless, it precludes intermediate commanders from setting aside separation actions for abuse of illegal drugs, referring such actions to the separation authority. The inconsistency in the language between these two policies contributes to a gap that allows drug offenders to remain in the Service despite the clear intent posited in AR 600-85. Although AR 600-85 directly pertains to drug abuse and, therefore, is more relevant to the issue of drug offenders, AR 635-200 is the regulation most often consulted for misconduct separations. The result is apparent in the 1,852 felony drug offenders who were not separated in FY2010 (via Chapter 9 or Chapter 14 drug abuse).

RECOMMENDATIONS

- ❖ HQDA should promulgate policy language in AR 600-85 across all regulations governing separation of drug offenders, with the express intent to eliminate illicit drug use in the Army.
- ❖ Senior commanders should monitor drug separation trends across subordinate commands to ensure fair and equitable implementation.

(b) Prescription Medication Abuse

The Army issued new policy in February 2011 that limits prescription use to six months from the date of issuance and provides only a 30-day supply at a time, with a maximum of five refills. The intent of this policy is to reduce illicit drug use associated with prescription medication, which is often associated with severe outcomes including drug overdose and death. Although the policy has been issued Army-wide, it has yet to be fully implemented, and therefore has not reduced the largest identified gap in drug surveillance. Currently the Medical Review Officer (MRO) process has not incorporated the policy to document and refer illicit use of prescription medication to commanders. MRO implementation is awaiting Army-wide notification to ensure all leaders and Soldiers understand the ramifications of this policy, which will consider use of medication beyond its six month prescription window as illicit use (Chapter III, section 3.b(4)(b)).

RECOMMENDATIONS

- ❖ HQDA should develop and distribute an Army STRATCOM to notify leaders and Soldiers that use of prescription medication beyond its expiration may be deemed illicit use, followed by a scheduled date for policy implementation.

(c) Other Multiple Felony Offenders

Again, although the Army has made progress in reducing the number of multiple felony offenders with a significant increase in misconduct related separations year over year, it still lacks definitive policy guidance—similar to drug related separations—for processing separation of other multiple felony offenders (see Chapter III, section 3.c(1)). Such policy formulation could significantly reduce felony offenders but, at a minimum, should address processing separations of violent felony offenders. This category of offenders arguably has a more adverse impact on victims and individual / unit readiness than multiple drug offenders. One can rationally question why the Army mandates processing of administrative separation for a second drug offense (felony) or a second alcohol-related misconduct (misdemeanor) but lacks similar policy for processing the separation of any other second felony offender, whether for sex crimes, aggravated assault, fraud, etc. In other words, why would the Army, for example, retain a one-time violent sex offender (adversely adjudicated) let alone a multiple violent sex offender for the same crime?

RECOMMENDATIONS

- HQDA should formulate policy to provide guidance for separation of Soldiers who are adversely adjudicated for a second time felony offense. While such policy should retain commander discretion for mitigating circumstances, it would increase the uniform application of administrative and disciplinary actions pertaining to felony offenders.

3. Health and Discipline-Related Risk Factors

There are two specific sub-populations within the Army that require leaders' attention. Many Soldiers and veterans have a foot in both camps. As addressed in Chapter II of this report, many individuals are struggling with wounds, injuries and illnesses incurred as a result of their military service; a significant portion is suffering from invisible wounds associated with physical and behavioral health wounds, injuries and illnesses. As discussed in Chapter III, there is also a significant population demonstrating criminal or high-risk behavior resulting in varying degrees of indiscipline.

a. Coupling Health and Discipline

One of the most important themes in this report is the convergence between Soldier health and discipline. These two sub-populations often require similar referrals and treatment associated with comorbid conditions that can comprise similar behavioral manifestations including drug and alcohol abuse, aggression-related misconduct, and other symptoms and manifestations related to cumulative stress. For example, a Soldier who commits spousal or child abuse, in fact, may be suffering from post traumatic stress, depression or alcohol abuse or dependence. As indicated in Chapter II, research has shown individuals suffering from PTS, depression or alcohol abuse are more likely to commit partner aggression. Similarly, a Soldier with a positive urinalysis test may be abusing drugs as a form of self medication or may have become dependent on pain narcotics used to treat combat-related wounds or injuries. Both examples demonstrate the intersection between health and disciplinary issues that will require overlapping treatment and accountability measures.

Successful resolution of these issues must involve collaboration from a broad community of leaders and program managers. The “maze” model (figure IV-3), illustrates the relationship between risk and adverse outcomes, demonstrating why collaborative surveillance, detection and response efforts are

necessary and essential. “At-risk” Soldiers (help seeking) will generally enter and exit the maze, seeking treatment, achieving recovery and then returning back to the baseline (healthy) population. Some individuals enter and exit the maze in this fashion numerous times over the course of their careers. This is what is referred to as the health maintenance cycle. “High-risk” Soldiers, however, left undetected may enter and continue to spiral toward the center with increasingly more severe consequences in each subsequent passage. There are also instances where Soldiers enter the maze and—with no previous and apparent demonstrations of high-risk behavior—spiral to the center with potentially fatal consequences (e.g., suicide attempt, suicide or drug overdose).

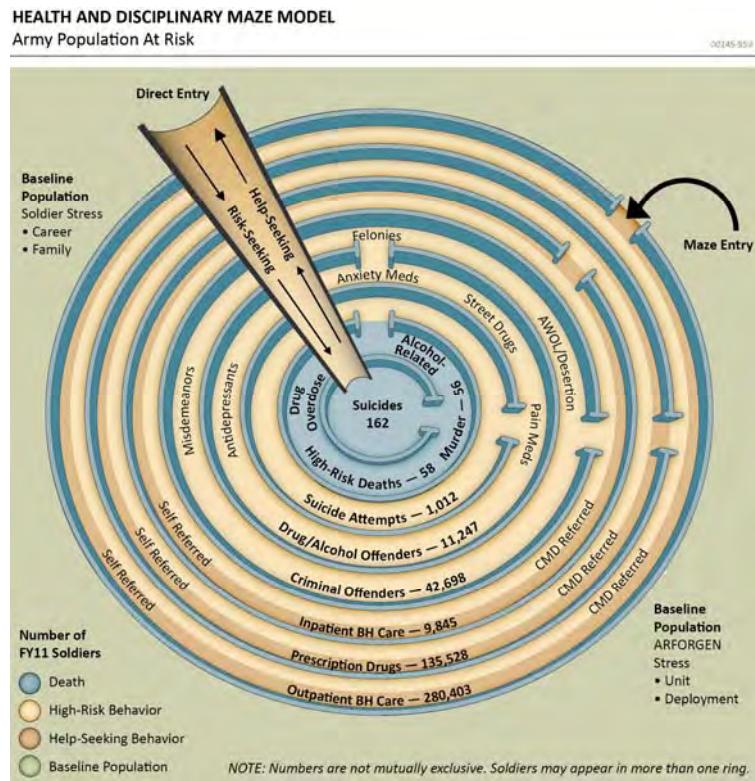


Figure IV-3: Health and Disciplinary Maze Model

b. Strategy for Surveilling and Detecting At-Risk and High-Risk Behavior

The orb chart at figure IV-4 provides perspective regarding the population size of the concentric rings that compose the maze (populations may overlap as individual Soldiers may be reflected in two or more rings). The large red orb represents the total population of Soldiers serving on active duty, roughly 700,000 (active duty, including mobilized USAR and ARNG), dwindling to 114 high-risk deaths in the gray orb at the far right.¹⁹ This juxtaposition provides a nice illustration of the perspective size of each sub-population when compared against the total active duty population. The dark orange orb represents those individuals who received outpatient behavioral healthcare (280,403 unique individuals in FY2011); the blue orb represents Soldiers with prescriptions (anti-anxiety, anti-depressant and narcotic pain management) lasting more than 15 days (135,528) and the light orange orb represents Soldiers who received in-patient behavioral health care (9,845). Together these three orbs represent the population of predominately help-seeking (‘at-risk’) Soldiers in what is referred to as the health maintenance cycle. The size of the orbs indicates the Army has dramatically increased its healthcare capacity and leader involvement and quite possibly reduced stigma associated with physical and behavioral health care. This is good news.

The remaining orbs, beginning with the dark green orb (criminal offenders) and moving right, represent those Soldiers exhibiting some type of ‘high-risk’ behavior, including criminal offenses, drug and alcohol offenders, suicide attempts, high-risk deaths and suicides. As shown in figure IV-4, these sub-populations are relatively small, particularly in the case of suicides and equivocal deaths when compared against the baseline population. The point is made not to diminish the significance of these

¹⁹ The 114 combines 56 murderers with 58 high-risk accidental or undetermined deaths; victims of the murders were not included because they represent both military and civilian personnel.

high-risk behaviors; but, to show the difficulty of identifying and targeting these specific individuals within the larger population. For example, it would have been impossible to predict the 162 individual Soldiers who committed suicide in FY2011 from among the greater Army population serving in the same period.

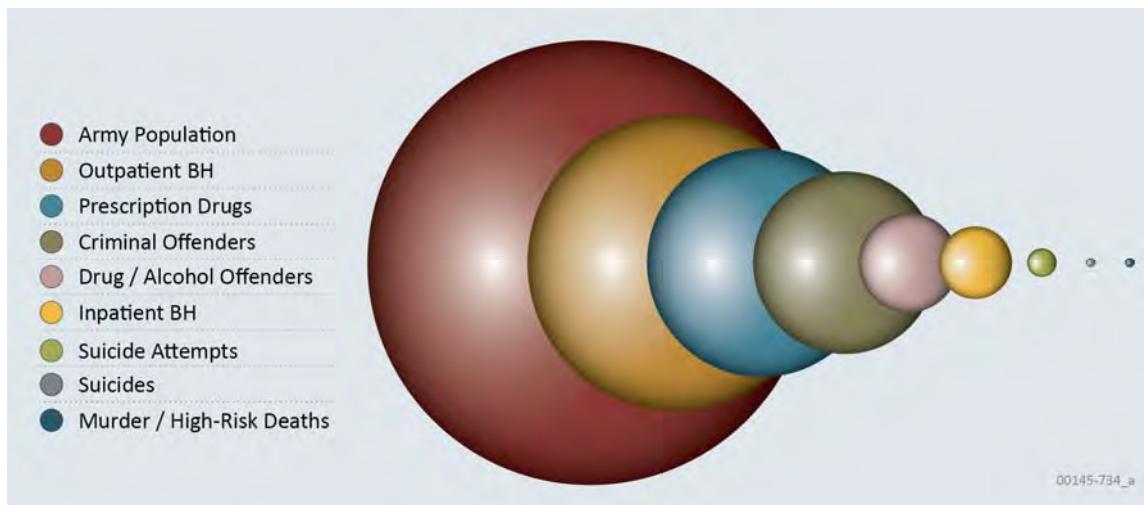


Figure IV-4: At-Risk and High-Risk Perspective (Orb Chart)

A much more effective strategy for mitigating outcomes associated with the most serious high-risk behavior is illustrated at figure IV-5. The strategy is based on increased surveillance, detection and response to more detectable at-risk and high-risk Soldiers (larger orbs) who may be at greater risk for these more serious but less prevalent outcomes (smaller orbs). In other words, reducing the size (by reducing risk) of the sub-populations associated with larger orbs (e.g., prescription medication abuse, criminal offenders, drug / alcohol offenders) may reduce the size of the sub-populations among the smaller orbs—those whose high-risk behavior often lead to more serious outcomes including death. An analysis of multiple felony offenders is illustrative of this relationship. It found that deaths among multiple felony offenders from FY2001-11 were approximately 440 per 100,000 Soldiers as compared to 42 per 100,000 for the Army population at large.²⁰ Reducing the risks associated with the larger population (multiple felony offenders) would have reduced the smaller population (high-risk deaths).

This strategy focuses surveillance, detection and response systems on some aspects of both at-risk and high-risk populations. Obviously, these two populations overlap, with behavioral healthcare and medicated populations (orbs) potentially falling into both categories due to the potential risk associated with some Soldiers who are command-referred (not necessarily help seeking) or who may potentially abuse their prescription medication. Perhaps less obvious is the fact that some high-risk behavior falls into both categories, such as the health and high-risk aspects of drug and alcohol abuse. These gray areas between health and high-risk behavior require a new (or at least a renewed) way of thinking about appropriate surveillance, detection and response. Commanders cannot simply respond to one without at least considering the other. For example, commanders who refer Soldiers to behavioral healthcare should follow up with the healthcare provider to facilitate treatment as well as to mitigate potential high-risk behavior stemming from the condition or treatment. Likewise, Soldiers with multiple prescriptions or whose prescriptions may impact their performance or readiness should be monitored for compliance as well as for the risk associated with its use.

²⁰ Death rates are calculated based on death investigations conducted by CID and do not include all deaths related to vehicular accidents, natural deaths or combat-related deaths.

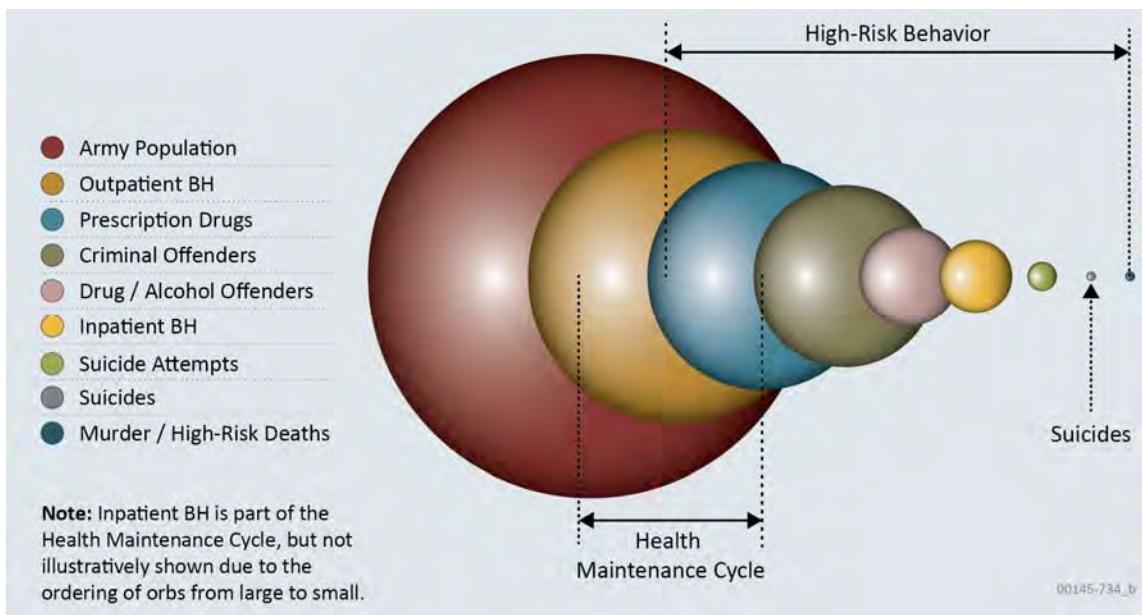


Figure IV-5: Targeting High-Risk Behavior

This strategy also recognizes the interplay between health and disciplinary factors on another level. For example, leaders and healthcare providers now recognize that many individuals who suffer from PTSD or depression are at greater risk for alcohol and substance abuse, aggressive behavior, failed relationships, among other at-risk and high-risk outcomes. This linkage between at-risk and high-risk outcomes forms the basis of the maze model, which can only be mitigated through an increase in command intervention and / or help-seeking behavior.

Today, the subject of post-combat stressors and their impact on health and discipline during reintegration is as fundamental to leading Soldiers as combat preparation during pre-deployment. It is a subject that requires increased emphasis in Army PME, training, and mission planning and execution. And as the Army continues to learn based on the results of the *Army Study to Assess Risk and Resilience In Servicemembers* (STARRS), *National Intrepid Center of Excellence* (NICoE), and other research and analyses, it must continue to reformulate policy and programs. In the meantime, leaders must remain vigilant in identifying and responding to Soldiers whose health or high-risk behavior places them at increased risk.

4. The Leadership Role

The Army is well postured to close the remaining gaps in health and disciplinary surveillance, detection and response systems. With few exceptions Army leaders have made tremendous strides in improving policy and policy implementation. At the highest levels there are a few areas in grand policy guidance that require additional emphasis but the majority of the work ahead in implementing a sound strategy to promote health and discipline remains with commanders, especially among those at brigade, battalion and company levels. This section highlights the importance of active communication and engagement among commanders and program managers with a specified intent to increase policy compliance. It draws on the analyses provided throughout this report to highlight recommendations for commanders and program managers regarding specific areas of policy implementation including health and disciplinary surveillance and detection systems; administrative and disciplinary actions; and good

order and disciplinary measures. Thorough and standard compliance with these recommendations—many of which are based on existing policy—will reduce the remaining gaps in health and disciplinary surveillance, detection and response systems.

a. Communicating and Engaging

Commanders and program / service providers must actively communicate and coordinate to provide 360° visibility of the at-risk and high-risk Soldier sub-populations. Healthcare providers must communicate Soldier diagnosis, prognosis and essential elements of the treatment plan in accordance with HIPAA (e.g., medication and potential side effects, treatment options, medical appointments, profiles). This information is critical to commanders (and the chain of command) who are best positioned to observe and monitor these Soldiers day to day; provide relevant feedback on treatment progress; and communicate the impact of treatment on Soldiers' schedules, duty performance and readiness. Moreover this dialogue is absolutely critical in balancing performance expectations with treatment and profile limits and, ultimately, in determining Soldier status with respect to OPTEMPO, upcoming deployments or even ongoing administrative or disciplinary measures.

Commanders must fully measure the potential rehabilitation of Soldiers against the potential for continued indiscipline, especially in cases involving substance abuse / dependency and other behavioral health issues frequently associated with misconduct (prolonged stress, anger, disruptive behavior, addictions, etc.). In order to do so, commanders must implement policy evenly to meet the intent to reduce the margins of unfit Soldiers in the non-ready pool who must either find sanctuary or continued treatment outside of the military. This means that commanders and program providers again must collaborate to reduce the bureaucracy and time associated with medical evaluation boards and administrative separations designed to determine health and readiness prognosis and disposition. Even if time associated with the medical narrative summary is reduced, fitness determination must be delegated to appropriate command levels to enact policy intent. This is especially true where health and disciplinary accountability intersect in the determination and disposition process.

Leaders and program managers must continue to emphasize community participation across a variety of interdisciplinary forums, not least of which is the CHPC (Community Health Promotion Council). Senior Army leader engagements have confirmed that installations around the world have made significant gains in community participation in accordance with AR 600-63, *Army Health Promotion*, and DA PAM 600-24, *Health Promotion, Risk Reduction and Suicide Prevention*. These policies bring together IMCOM, MEDCOM and tenant organization leaders to solve challenges confronting community health and discipline. At the center, the CHPC, informed by other collaborative forums, advocates community interaction among commanders, health and risk reduction program managers to provide community-based solutions. The CHPC also provides an oversight council that can review, measure and assess other required collaboration forums including health triad engagements; and lessons learned from Family Advocacy Program's (FAP's) case review committee, fatality review boards, and Sexual Harassment / Assault Response & Prevention (SHARP) Program's Sexual Assault Review Board (SARB), among others.

b. Implementing Policy and Programs

The Army has gained traction in enhancing health-related surveillance, detection and response policy and programs. These include legacy as well as new programs and protocols such as the Medical Protection System (MEDPROS), tele-medicine, Army Substance Abuse Program (ASAP), FAP, Confidential

Alcohol and Treatment Education Pilot (CATEP), Comprehensive Soldier Fitness (CSF) with its Global Assessment Tool (GAT), the annual Periodic Health Assessment (PHA), Post Deployment Health Assessment (PDHA), Post Deployment Health Reassessment (PDHRA), mTBI post-blast protocols, and many others covered throughout this report. Each of these policies and programs can provide discrete and multiple touch points for leader surveillance, detection and potential response to promote and sustain Soldier health or to reduce risks associated with wounds, injuries or illnesses.

Effective policy implementation requires active leader involvement from start to finish. Leaders must connect the dots from surveillance to detection to response. For example, linking substance dependency to program enrollment and treatment success requires coupling the identification of the problem to the development of a treatment plan. This involves collaborative engagement of the unit chain of command, ASAP counselor and affected Soldier. Any gaps or seams in these linkages can degrade, if not prevent, treatment success. In the example above, failure to refer a Soldier with a positive urinalysis (UA) to ASAP or failure to enroll an alcohol-dependent Soldier into ASAP will result in the failure to treat the Soldier. Although these policy and program linkages seem relatively straightforward, Army leaders continue to miss critical opportunities to enhance program surveillance, detection and response. For example, of 7,670 unique Soldiers with a positive urinalysis in FY2010, 2,935 went un-referred to ASAP and of those referred, 720 were not enrolled into treatment or education programs (i.e., Army Drug and Alcohol Prevention Training). When these two populations are combined, 3,655 Soldiers who were identified as abusing drugs in FY2010 alone went untreated.

The most critical step is to increase command awareness regarding Soldier health and disciplinary information. A good example is the integration of health policies designed to holistically inform health surveillance, detection and response. The integration of MEDROS, PHA, PDHA and PDHRA systems, for instance, inform commanders and health providers as Soldiers move through the system (PCS, deployment, TDY). Commanders must ensure Soldiers meet appointment requirements for the PHA, PDHA and PDHRA before and after deployments in accordance with AR 40-501, *Standards of Medical Fitness*, 5 August 11. They must then check to ensure the results of those health screenings are reflected in their MEDPROS data which records Soldier health and readiness status. Failure to ensure Soldiers are screened and the data are updated into command systems may result in a missed opportunity to prevent, diagnose or treat physical or behavioral health injuries or related issues.

Likewise, compliance with health and disciplinary policy increases awareness among commanders and program managers to ensure Soldier accountability. Use of flag and bar actions or processing / referring Soldiers for potential suspension of security clearances, provide visibility of Soldiers pending disciplinary and administrative actions and suspends favorable actions including Soldier transition and retention processes through final adjudication. Similarly, DA Forms 4833 provide visibility of Soldier misconduct, health referrals, adjudication, and disciplinary and administrative actions taken. When uniformly implemented, these policies work together to provide a 360° awareness of Soldiers, ensuring due process for health care and appropriate accountability. They also inform other commanders and program managers regarding Soldier performance, reparation and recidivism as Soldiers transition throughout the Army. This provides essential continuity regarding Soldier health and discipline by providing commanders and program managers with critical information to inform their decisions during adjudication of subsequent acts of misconduct. Ultimately, these policies act to promote health and disciplinary standards and improve the readiness of the Force.

VIGNETTE— IMPORTANCE OF HEALTH TRIAD COMMUNICATION

A 22-year-old married PV2 redeployed in May 2010. He never completed his post-deployment health reassessment during reintegration or demobilization. He was recently diagnosed with PTS but his leaders were unaware of the diagnosis. He reportedly became addicted to his pain medications as his behavior spiraled out of control. He became involved in a botched robbery and was facing 20 to 48 months incarceration. On 12 September 2011, he died of an apparent self-inflicted gunshot wound. His dog was scheduled to be euthanized that same day. His post-mortem toxicology screening found fluoxetine (anti-depressant), amitriptyline (anti-depressant often used to treat chronic pain or headaches) and oxycodone (pain medication) in his system.

This scenario is illustrative of the potential opportunities for leaders and healthcare providers—through surveillance and detection—to actively collaborate in response to an at-risk and high-risk individual.

c. Recommendations for Policy and Program Implementation

The following recommendations regarding policy implementation are based on analyses and conclusions throughout this report which, if enacted, will reduce remaining gaps in Army health and disciplinary surveillance, detection and response systems. Each recommendation is introduced by abbreviations for GO-level senior commanders (SC), commanders (CDR), program managers (PrM) or all participants (All) to specify the lead for policy implementation.

(1) Health and Discipline Surveillance and Detection:

- ❖ (PrM) Coordinate and communicate with commanders to increase awareness of the impact of medical conditions and treatment on Soldier performance and readiness in accordance with ALARACT 160 / 2010, *VCSA Sends on Protected Health Information*.
 - (All) Read and understand the broad military exemptions to HIPAA pertaining to Soldier readiness and performance.
 - (PrM) Incorporate HIPAA familiarization into Army PME.
- ❖ (CDR) Implement mTBI protocols in theater and on installations for all concussive events in accordance with ALARACT 193 / 2010, HQDA EXORD 253-10, *Management of Concussion / mTBI in the Deployed Setting*.
- ❖ (CDR) Ensure a 360° surveillance / awareness of prior offenses and other administrative and disciplinary actions during adjudication via DA Forms 4833 in accordance with ALARACT 209 / 2011, *Unit Commanders' Status Review of Commanders' Report of Disciplinary or Administrative Action, DA Form 4833*.
 - (CDR) Coordinate with installation provost marshal for DA Form 4833 for visibility of prior offenses.
 - (SC/CDR) Consider misdemeanors as an indicator of unit discipline and for repetitive offenders as a potential indicator of escalating high-risk behavior.
- ❖ (CDR) Increase UA surveillance and detection by testing 100% of unique Soldier population rather than 100% of end strength (consider conducting 100% urinalysis randomly).
- ❖ (CDR) Conduct routine H&W inspections in barracks.
 - (CDR) Use narcotic detector dogs during H&W inspections.

- (CDR) Increase surveillance of illicit use of prescriptions by reviewing labels for name, type of medication and expiration date (use of medication with expired prescription may = illicit use).
- (CDR) Incorporate drug paraphernalia and indications of synthetic drugs into unit H&W inspections in accordance with SA Directive, *Prohibited Substances (Spice in Variations)*, 10 February 2011.
- ★ (SC) Monitor subordinate commander compliance with administrative separations and disciplinary actions to ensure uniform and fair implementation across subordinate commands.
- ★ (SC) Monitor unit flag and bar actions to ensure appropriate administrative measures pending investigations and adjudication of alleged misconduct in accordance with ALARACT 386 / 2011, *Suspension of Favorable Personnel Actions*.
- ★ (SC) Monitor deployment rosters to identify deploying Soldiers who are flagged, barred, referred / enrolled for treatment, and pending adjudication and DA 4833 documentation.
- ★ (All) Incorporate surveillance, detection and response systems into existing readiness forums (e.g. monitor DA Form 4833 compliance, ASAP referrals and administrative separations during QTBS, staff calls, USRs, etc.).
- ★ (SC) Implement and participate in the recurring Armed Forces Disciplinary Control Board to provide broader situational awareness of environments conducive to high-risk behavior.
- ★ (CDR) Educate and mentor junior leaders on health and accountability policy, programs and processes via OPD and NCOPD.

≥ (2) Health Promotion and Referral:

- ★ (CDR) Schedule Soldiers for all health screenings including PHA, PDHA, and PDHRA for all phases of ARFORGEN in accordance with MEDCOM OPORD 1070 (FRAGO 7, 30 March 2011), *Comprehensive Behavioral Health System of Care Campaign Plan*.
 - (All) Refer Soldiers for further evaluation and treatment based on results of screening.
- ★ (CDR) Schedule Soldiers for health appointments, review and communicate with healthcare providers regarding profiles, document pertinent medical information affecting performance and readiness into MEDPROS.
- ★ (CDR) To the extent possible, do not remove Soldiers from health program enrollment for mission and training events to ensure program continuity and successful completion; if necessary, ensure re-enrollment.
- ★ (PrM) Actively coordinate care for Soldiers through communication with Soldier, pharmacist, other healthcare providers and commanders in accordance with OTSG / MEDCOM Policy 10-076, *Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants*.
 - (CDR) Actively communicate with Soldiers' primary care providers on issues of medical concern and respect limitations placed on Soldiers by their primary care managers due to medication side effects.
- ★ (CDR/ PrM) Monitor Soldiers with multiple prescriptions or whose prescriptions may impact their performance or readiness for regimen compliance as well as for the risk associated with its use in accordance with OTSG / MEDCOM Policy 10-076, *Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants (CNSD)*.

- (PrM) Conduct a comprehensive review for patients who received four or more medications which include one or more psychotropic agents and / or CNSD agents within 30 days.
- ★ (All) Participate in installation health and risk reduction programs and forums to increase health and accountability awareness and integration (e.g., CHPC, FAP [Case Review Committee], ASAP, SHARP, Risk Reduction, and Safety [Fatality Review Board]).
- ★ (SC/CDR) Develop policy to set conditions to promote help-seeking (stigma reducing) behavior. Help-seeking behavior is the result of initiative, problem solving, effective communication and compassionate leadership.
 - (CDR) Avoid conspicuous labeling or identification of Soldiers who seek physical and behavioral healthcare (e.g., suicide watch measures, high-risk rosters).
- ★ (CDR) Educate all Soldiers on pending policy implementation restricting prescription expiration to six months use, which may deem subsequent use as illicit in accordance with ALARACT 062 / 2011, *Changes to Length of Authorized Duration of Controlled Substance Prescriptions*.
- ★ (CDR) Actively facilitate Soldier transition through the MEB / PEB and IDES processes to ensure an accurate and thorough fitness for duty evaluation and appropriate disability determination.
- ★ (SC) Continue to evaluate confidential programs to balance program effectiveness, stigma reduction and command awareness.

(3) Administrative and Disciplinary Actions:

- ★ (CDR) Consult with legal counsel during implementation of all administrative and disciplinary actions to enhance awareness of the latest policy updates and to ensure legal sufficiency for proposed actions.
- ★ (CDR) Flag all Soldiers who allegedly committed an offense pending final outcome of an investigation / inquiry, final disciplinary and administrative action and DA Form 4833 documentation in accordance with ALARACT 386 / 2011, *Suspension of Favorable Personnel Actions*.
 - (CDR) Initiate Bar to Reenlistment for Soldiers adversely adjudicated, if appropriate.
- ★ (CDR) Refer all Soldiers to rehabilitation programs based on indicators associated with high-risk behavior and misconduct for assessment and treatment as appropriate; document referrals on DA Form 4833.
- ★ (CDR) Coordinate with CID and installation provost marshal for all information pertaining to Soldiers who allegedly commit criminal misconduct off-post:
 - (CDR) Evaluate the offense and civilian court adjudication for appropriate disciplinary and administrative action and subsequent documentation on DA Form 4833.
- ★ (CDR) Consider prior offenses and other administrative and disciplinary actions during adjudication to establish any potential patterns of misconduct that warrant additional measures (36% of 1st time drug offenders and 47% of 2nd time offenders will offend again).
- ★ (CDR) Ensure compliance with current policy (AR 600-85) regarding the initiation and processing of administrative separation for first and second drug offenses, respectively.
 - (CDR) Initiate administrative separation for Soldiers involved in two serious alcohol-related incidents within 12 months.

- ★ (CDR) Ensure that Soldiers processed for administrative separation reflect an appropriate characterization of service (e.g., OTH discharge) and re-entry code to prevent transition into the RC and reentry into Service.
- ★ (PrM) Refer Soldiers with positive UA to both commander and law enforcement simultaneously to reduce gaps in reporting and investigations.
 - (CDR) Ensure CID is notified of all allegations regarding drug offenses.
- ★ (CDR) Ensure DA Form 4833 with supporting documentation is completed and returned to installation law enforcement within the required 45 days.
 - (CDR) Document all relevant data in support of future disciplinary actions / adjudications (e.g. appropriate offenses, adverse action taken and appropriate referrals, etc.).
- ★ (CDR) Ensure Soldier security clearance referrals in situations involving criminal misconduct.
- ★ (SC/CDR) Establish appropriate administrative and disciplinary withhold based on the evaluation and assessment of actions taken across subordinate commands.
- ★ (CDR) Ensure immediate accountability of AWOL Soldiers:
 - (CDR) Request an expedited warrant for apprehension of high-risk AWOL Soldiers in accordance with ALARACT 366 / 2011, *Guidance for Commanders Request to Enter Deserter Warrants into the National Crime Information Center Database*.
 - (CDR) Use 31 day DFR process for low-risk Soldiers (Note: use of a warrant prior to 30 days should be a deliberate command decision to avoid unnecessary high-risk apprehensions).

IV (4) Good Order and Discipline:

- ★ (CDR) Actively monitor unit gains rosters to proactively sponsor and integrate incoming Soldiers into the formal chain of command to promote accountability.
 - (CDR) Integrate young Soldiers (particularly young female Soldiers) into a formal chain of command to prevent sex crime victimization.
 - (CDR) Assign Soldier buddy teams to increase visibility and accountability.
- ★ (CDR) Ensure that barracks visitation policies provide for appropriate restrictions limiting visitor numbers, visiting hours, alcohol and activities as appropriate.
 - (CDR) Ensure leader oversight and awareness of activities in the barracks, especially with respect to activities involving mixed company and alcohol consumption.
 - (CDR) Assign senior NCO and CQ roles and responsibilities for barracks overwatch as appropriate.
 - (CDR) Include appropriate limitation of visitation privileges for young female civilians.
- ★ (CDR/PrM) Respond to high risk behavior to first promote the health of the Soldier, and second to hold the Soldier accountable as appropriate.
- ★ (CDR) Coordinate with risk reduction programs (law enforcement, ASAP, FAP) regarding the status of investigations to ensure visibility of all relevant information during adjudication.
- ★ (SC) Assign military police (at installations available) to support CID drug suppression teams in accordance with ALARACT 163 / 2011, HQDA EXORD 183-11, *Investigation of Incidents Involving Controlled Substances*.

d. A Final Note Regarding Policy Implementation

Although decentralization of policy implementation at the installation level is imperative, one caution lies in the inherent weakness associated with its delegation: a natural tendency towards parochialism through the adaptation of official policies and programs based on local environments, conditions and leader initiatives. Installation leadership must dampen unconstrained initiatives that lead to the proliferation of hundreds of local programs, which resulted in the de-standardization of official Army policy, programs and processes dubbed “the blooming of a thousand flowers” by the VCSA during his installation tour in early 2009. This finding prompted a HP&RR Task Force survey in 2010 that found approximately 350 programs Army-wide of which only 70 were identified as official Army programs based on official policy and program funding.²⁹⁰ The majority of these local programs or initiatives were redundant to official programs, ad hoc in nature and were resourced using diverted program funds or unfinanced requirements. This caution should not stifle the assessment of emerging requirements, development of valid program pilots or feedback from the voice of the customer, but, rather, should advocate that these initiatives should be formalized and standardized during the Army’s requirements generation process via official Army validation and resourcing. This will ensure that the Army can track the efficiency and effectiveness of newly authorized pilots, provide standard programs / services from installation to installation and measure its return on investment in an increasingly constrained environment.

5. Summary

Leaders at all levels must recognize that while our Army has completed operations in Iraq and will eventually do the same in Afghanistan, this does not equate to less responsibility or fewer demands on them in coming days. To the contrary, arguably more will be asked of them during upcoming periods of reintegration and reset. This is certainly the case as we look ahead to the requirement to transition a significant portion of our Force from military to civilian life, to include many suffering from wounds, injuries and illnesses incurred in service to our Army and the Nation. Leaders will also be required to select and separate Soldiers either unable or unwilling to serve as demonstrated by their behavior.

The challenges facing our Army’s leaders in the days ahead are incredibly complex and consequential. They are made even more difficult by circumstances, namely projected cuts to budgets and end strength, continued demand for forces and the ‘wear and tear’ on our people and equipment. Tough decisions will need to be made that will involve and directly impact people, many of whom have selflessly served and sacrificed on behalf of our Nation for the better part of a decade. Leaders will need to consider a variety of alternatives and possible solutions, some as unique as the circumstances they are expected to address. This may include, for example, transitioning Soldiers enrolled in the Warrior Transition Program sooner to the VA for long-term disability determination and treatment. The Army’s efforts must also be proactive. Intervening early to address high-risk behavior related to Soldier health and discipline will enable avoidance of further negative outcomes. Likewise, helping Soldiers to successfully transition back to civilian life will reduce unnecessary stress on them and their Families and reduce the financial impact on the Army.

Making the right choices for Soldiers and for the Army will require an understanding of the various issues and challenges specific to the health and discipline of the Force, clear direction, sound policy, even implementation, effective employment of surveillance, detection and response systems, and an unwavering commitment to the readiness of our Army. Recognizing that much of what our leaders will be dealing with in coming days represents “uncharted territory,” it is essential that senior Army leaders

at the HQDA level provide clear strategic direction now. This will help inform policy formulation and ensure convergence at key points of intersection. It will also enable even implementation and adherence at appropriate levels across the Force.

Finally, the magnitude and complexity of the challenges facing our leaders in the days ahead demand communication at all levels, vertically and horizontally, across domains. Communication is key to raising awareness which in turn enables synchronization and unity of effort. A lack of communication will ultimately lead to gaps in the Army's surveillance, detection and response systems. Ultimately, it is our Soldiers—America's Soldiers—who will suffer the effects of those gaps. We owe it to them and to their Families to do everything possible to generate health and discipline and preserve the readiness of our Force now and in the future.

IV

Glossary of Abbreviations

A	B	C
ABHIDE Army Behavioral Health Integrated Data Environment	ARNG Army National Guard	CDR Commander
AC Active Component	ASAP Army Substance Abuse Program	CG Commanding General
ACE Ask, Care and Escort	AUSA Association of the United States Army	CHPC Community Health Promotion Council
ACI2 Automated Criminal Investigative and Intelligence System	AW2 Army Wounded Warrior Program	CHU Containerized Housing Unit
ACSAP Army Center for Substance Abuse Programs	AWOL Absent Without Leave	CID Criminal Investigation Command (formerly Division)
ACSIM Assistant Chief of Staff for Installation Management		CJCS Chairman, Joint Chiefs of Staff
AD Active Duty	BASD Basic Active Service Date	CMF Career Management Field
AFME Armed Forces Medical Examiner	BCT Brigade Combat Team	CNSD Central Nervous System Depressant
AIT Advanced Individual Training	BESS Balance Error Scoring System	COAD Continuation on Active Duty
ALARACT All Army Activities (Message)	BH Behavioral Health	COAR Continuation on Active Reserve
ALCID All Criminal Investigation Command (Message)	BOG Boots on the Ground	COMPO Component
AMEDD Army Medical Department		CONUS Continental United States
ARFORGEN Army Force Generation	CAB Combat Action Badge	COPS Centralized Operations Police Suite
AR Army Regulation	CATEP Confidential Alcohol Treatment and Education Pilot	COSC Combat Operational Stress Control
	CBRN Chemical, Biological, Radiological, Nuclear	COSR Combat and Operational Stress Reaction
	CDC Centers for Disease Control and Prevention	

CRM Comprehensive Resilience Module	DFR Dropped from the Rolls	FORSCOM US Army Forces Command
CSF Comprehensive Soldier Fitness	DMDC Defense Manpower Data Center	FOOU For Official Use Only
CTE Chronic Traumatic Encephalopathy	DoD Department of Defense	FRAGO Fragmentary Order
CTP Comprehensive Transition Plan	DoDI Department of Defense Instruction	FRG Family Readiness Group
CY Calendar Year	DoDSER Department of Defense Suicide Event Report	FY Fiscal Year
D		
DA Department of the Army	DoJ Department of Justice	GAT Global Assessment Tool
DA PAM Department of the Army Pamphlet	DST Drug Suppression Team	GO General Order
DAMIS Drug and Alcohol Management Information System	DSM-III Diagnostic and Statistical Manual of Mental Disorders, Third Edition	H
DCoE Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury	DTM Directive-Type Memorandum	H.E.A.D.S. Headaches and/or vomiting; Ears ringing; Amnesia and/or altered consciousness and/or loss of consciousness; Double vision and/or dizziness; Something feels wrong or is not right
DCS Deputy Chief of Staff	DUI Driving Under the Influence	HIPAA Health Insurance Portability and Accountability Act
DD Form Department of Defense Form	DWI Driving While Intoxicated	HP&RR Task Force Health Promotion and Risk Reduction Task Force
DEA Drug Enforcement Agency	E	
DES Director of Emergency Services	EMS Emergency Medical Services	HP/RR/SP Health Promotion, Risk Reduction and Suicide Prevention
DES Disability Evaluation System	ETS Expiration Term of Service	HQDA Headquarters, Department of the Army
DFAS Defense Finance Accounting System	F	H&W Health and Welfare
	FAP Family Advocacy Program	
	FBI Federal Bureau of Investigation	
	FM Field Manual	

I		
IACP Installation Access Control Program	MEDPROS Medical Protection System	NCO Non-Commissioned Officer
IAW In Accordance With	MEPS Military Entrance Processing Station	NCOPD Non-Commissioned Officer Professional Development
IDES Integrated Disability Evaluation System	MFLC Military Family Life Consultant	NICoE National Intrepid Center of Excellence
I.E.D. Injury/Evaluation/Distance	MHAT Mental Health Advisory Team	NIMH National Institute of Mental Health
IED Improvised Explosive Device	MMRB MOS / Medical Retention Board	O
ImPACT Immediate Post-Concussion Assessment and Cognitive Testing	MOS Military Occupational Specialty	OEF Operation Enduring Freedom
IOM Institute of Medicine	MOS Military OneSource	OIF Operation Iraqi Freedom
J	MP Military Police	OMPF Official Military Personnel File
JDBP Journal of Developmental & Behavioral Pediatrics	MPI Military Police Investigator	OPD Officer Professional Development
LOD Line of Duty	MRAP Mine Resistant Ambush Protected	OPMG Office of the Provost Marshal General
L	MRO Medical Review Officer	OPORD Operations Order
M	MRT Master Resilience Trainer	OPTEMPO Operational Tempo
MCEC Military Child Education Coalition	MST Military Sexual Trauma	OTJAG Office of the Judge Advocate General
MCM Manual for Courts-Martial	mTBI Mild Traumatic Brain Injury	OTSG Office of The Surgeon General
MDE Major Depressive Episode	MTF Medical Treatment Facility	Oxys Oxycodone and/or Oxymorphone
MEB Medical Evaluation Board	MTT Mobile Training Team	P
MEDCOM US Army Medical Command	NARSUM Narrative Summary	PCP Phencyclidine

PCS Postconcussive Syndrome	Q	SP Suicide Prevention
PCS Permanent Change of Station	Q&A Question and Answer	SSN Social Security Number
PDES Physical Disability Evaluation System	QTB Quarterly Training Brief	SSRG Suicide Senior Review Group
PDHA Post-Deployment Health Assessment	R	STARRS Study to Assess Risk and Resilience in Servicemembers
PDHRA Post-Deployment Health Reassessment	RC Reserve Component	STRATCOM Strategic Communication
PEB Physical Evaluation Board	RESPECT-Mil Re-engineering Systems of the Primary Care Treatment in the Military	T
PET Positron Emission Tomography	RMC Return to Military Control	TBI Traumatic Brain Injury
PHA Periodic Health Assessment	ROI Report of Investigation	TDY Temporary Duty
PHI Protected Health Information	RR Risk Reduction	TIS Time In Service
PM Provost Marshal	S	TRIAP TRICARE Assistance Program
PME Professional Military Education	SA Secretary of the Army	U
PMG Provost Marshal General	SA Substance Abuse	UA Urinalysis
PMTF Pain Management Task Force	SAC Standard Assessment of Concussion	UCLA University of California, Los Angeles
PrM Program Manager	SAMHSA Substance Abuse and Mental Health Services Administration	UCMJ Uniform Code of Military Justice
PSA Public Service Agreement	SAT Standardized Assessment Tool	UCR Uniform Crime Report
PTS Post Traumatic Stress	SC Senior Commander	USADIP US Army Deserter Information Point
PTSD Post Traumatic Stress Disorder	SHARP Sexual Harassment/Assault Response and Prevention	USAMRMC US Army Medical Research and Materiel Command
	SF Standard Form	USAR United States Army Reserve

		Ranks	
USAREC	US Army Recruiting Command	GEN	
USCENTCOM	United States Central Command	General	
USR	Unit Status Report	LTG	Lieutenant General
V		MG	Major General
VA	Department of Veterans Affairs	BG	Brigadier General
VCSA	Vice Chief of Staff of the Army	COL	Colonel
W		LTC	Lieutenant Colonel
WCTP	Warrior Care and Transition Program	MAJ	Major
WLC	Warrior Leader Course	CPT	Captain
WRAIR	Walter Reed Army Institute of Research	1LT	First Lieutenant
WT	Warrior in Transition	2LT	Second Lieutenant
WTC	Warrior Transition Command	CW5	Chief Warrant Officer Five
WTU	Warrior Transition Unit	CW4	Chief Warrant Officer Four
		CW3	Chief Warrant Officer Three
		CW2	Chief Warrant Officer Two
			W01
			Warrant Officer One
		CSM	Command Sergeant Major
		SGM	Sergeant Major
		1SG	First Sergeant
		MSG	Master Sergeant
		SFC	Sergeant First Class
		SSG	Staff Sergeant
		SGT	Sergeant
		CPL	Corporal
		SPC	Specialist
		PFC	Private First Class
		PV2	Private
		PVT	Private

This page has been left blank intentionally.

Endnotes

Unless cited otherwise, all vignettes and figures are provided by the Department of the Army.

¹ History Channel. 2008. Statistics about the Vietnam War. *History.com*. <http://www.vhfcn.org/stat.html> (accessed October 1, 2011).

² United States Army. 2011. 38th Chief of Staff, Army Initial Guidance and Thoughts. September 14. <http://www.army.mil/leaders/csa/>. (accessed October 28, 2011).

³ Larsen, Dave. 2011. NCO's Action Saves Soldier's Life. October 21. *Army Times*. www.army.mil/article/67739 (accessed October 25, 2011).

⁴ Committee on the Initial Assessment of Readjustment Needs of Military Personnel, Veterans, and Their Families. 2010. *Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*. Washington, D.C.: National Academies Press.

⁵ United States Department of Defense. Defense Manpower Data Center. 2011. Global War on Terrorism Casualties by Military Service Component -- Active, Guard and Reserve, September 19. *Defense Manpower Data Center Data Analysis and Programs Division*.

http://siadapp.dmdc.osd.mil/personnel/CASUALTY/gwot_component.pdf (accessed September 19, 2011).

⁶ United States Army Medical Command. 2011. Soldier Medical Readiness Campaign Plan 2011 – 2016, Version 1.2, May 2011. United States Army.

⁷ United States Army Warrior Transition Command. 2011. Briefing to the DoD Task Force on the Care, Management and Transition of Recovering Wounded, Ill and Injured Members of the Armed Forces. February 22. (<http://dtf.defense.gov/rwtf/m02/m02pa02.pdf>) (accessed October 1, 2011).

⁸ Satel, Salley. 2011. PTSD's Diagnostic Trap: Locking some veterans into long-term dependence. *Policy Review* no. 165, (February) <http://www.hoover.org/publications/policy-review/article/64396> (accessed October 4, 2011).

⁹ Kehle, Shannon M., Melissa A. Polusny, Maureen Murdoch, Christopher R. Erbes, Paul A. Arbisi, Paul Thuras, and Laura A. Meis. 2010. Early mental health treatment-seeking among US National Guard Soldiers deployed to Iraq. *Journal of Traumatic Stress* 23, no. 1. (February): 33-40.

¹⁰ United States Department of Defense. 2010. Medical Surveillance Monthly Report. Armed Forces Health Surveillance Center. *Medical Surveillance Monthly Report*, 17, no. 11:3. April.

http://www.afhsc.mil/viewMSMR?file=2010/v17_n04.pdf#Page=01 (accessed October 2, 2011).

http://www.armymedicine.army.mil/reports/mhat/mhat_vii/J_MHAT_7.pdf (accessed October 1, 2011).

¹¹ United States Department of Defense. 2011. Medical Surveillance Monthly Report. Armed Forces Health Surveillance Center. *Medical Surveillance Monthly Report*, 18, no. 4:3. April.

http://www.afhsc.mil/viewMSMR?file=2011/v18_n04.pdf#Page=01 (accessed October 2, 2011).

¹² United States Army Medical Command. 2010. OPORD 10-70, *Comprehensive Behavioral Health System of Care Campaign Plan*. Virginia: September. Department of the Army.

¹³ *Ibid.*

¹⁴ Jansen, Steve. 2011. Knocked Out: Bell Ringing. *Houston Press*, August 17.

<http://www.houstonpress.com/2011-08-18/news/knocked-out-bell-ringing/> (accessed October 11, 2011).

¹⁵ Bergsneider Marvin, David A. Hovda, Stefan M. Lee, Daniel F. Kelly, David L. McArthur, Paul M. Vespa, Jae Hong Lee, Sung-Cheng Huang, Neil A. Martin, Michael E. Phelps, and Donald P. Becker. 2000. Dissociation of cerebral glucose metabolism and level of consciousness during the period of metabolic depression following human traumatic brain injury. *Journal of Neurotrauma* 17, no. 5. (May): 389-401.

¹⁶ Schwarz, Alan. 2011. Duerson's Brain Trauma Diagnosed. *The New York Times*. May 2.

<http://www.nytimes.com/2011/05/03/sports/football/03duerson.html> (accessed October 11, 2011).

¹⁷ Washington State Department of Health, Division of Environmental Health, Office of Environmental Health, Safety, and Toxicology. <http://www.doh.wa.gov/ehp/ts/School/concussion.htm> (accessed October 14, 2011).

¹⁸ Sports Concussions.Org. <http://www.sportsconcussions.org/laws.html> (accessed October 1, 2011).

¹⁹ Faure, Caroline, E. 2011. Get Current on Concussion: Identification and Management Strategies for Coaches, Parents, Athletes & Medical Practitioners. Idaho State University, *Fall 2011 Newsletter*.
<http://wwwisu.edu/firstmonday/> (accessed October 1, 2011).

²⁰ *Ibid.*

²¹ Carino, Michael. 2011. Traumatic Brain Injury Trend for Total Army. September 19. Virginia: Office of the Army Surgeon General.

²² *Ibid.*

²³ *Ibid.*

²⁴ Directive-Type Memorandum (DTM) 09-033, "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting" June 21, 2010 with updates on February 22, 2011. <http://www.dtic.mil/whs/directives/corres/dir3.html> (accessed October 1, 2011).

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ United States Army. 2011. All Army Activities (ALARACT) message 214/2011 – HQDA EXORD 242-11, Warrior Concussion/mild Traumatic Brain Injury. June 7.

²⁸ Directive-Type Memorandum (DTM) 09-033, "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting" June 21, 2010 with updates on February 22, 2011. <http://www.dtic.mil/whs/directives/corres/dir3.html> (accessed October 1, 2011).

²⁹ 22nd Annual National Memorial Day Concert on PBS. <http://radiopatriot.wordpress.com/2011/05/29/22nd-annual-national-memorial-day-concert-on-pbs/> (accessed September 15, 2011).

³⁰ Summerall, E. Lanier. 2007. Traumatic Brain Injury and PTSD. January 1. Department of Veterans Affairs. <http://www.ptsd.va.gov/professional/pages/traumatic-brain-injury-ptsd.asp> (accessed October 5, 2011).

³¹ Stars and Stripes, European edition. 2011. More troops being diagnosed with mild brain trauma. September 28. <http://www.stripes.com/news/special-reports/traumatic-brain-injury/more-troops-being-diagnosed-with-mild-brain-trauma-1.156340> (accessed November 9, 2011).

³² Jordan, Bryant. 2010. MOH Recipients Push PTSD Counseling. *Military.com*, June 8. http://www.triwest.com/en/About-TriWest/triwest-news/corp-news-archive/2011/02/medal-of-honor-recipients-push-ptsd-counseling/MOHRecipients_PTSDCounseling.pdf (accessed November 9, 2011).

³³ American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders: DSM- III* (3rd ed). Washington, D.C.: American Psychiatric Association.

³⁴ Spitzer, Robert L., Michael B. First, and Jerome C. Wakefield. 2007. Saving PTSD from itself in DSM-V. *Journal of Anxiety Disorders* 21, no. 2: 233-241.

³⁵ Hoge, Charles W. 2011. Interview by COL Mark A. Jackson. Pentagon, Washington, D.C. November 2.

³⁶ United States Army Medical Command. 2011. WTC/WTU/MEDCOM Services for TBI & PTSD: Overview. <http://dtf.defense.gov/rwtf/m02/m02pa05.pdf> (accessed October 22, 2011).

³⁷ McNally, Richard. J. 2007. Revisiting Dohrenwend et al.'s revisit of the National Vietnam Veterans Readjustment Study. *Journal of Traumatic Stress*, 20 (August) 481–486.

³⁸ Hoge, Charles W. 2011. Interview by COL Mark A. Jackson. Pentagon, Washington, D.C. November 2.

³⁹ Doctor, Jason N., Lori A. Zoellner, and Norah C. Feeny. 2011. Predictors of Health-Related Quality-of-Life Utilities Among Persons With Posttraumatic Stress Disorder. *Psychiatric Services* 62, (March): 272-277.

⁴⁰ Dao, James. 2010. VA is Easing Rules to Cover Stress Disorder. *New York Times*, July 7. <http://www.nytimes.com/2010/07/08/us/08vets.html> (accessed October 1, 2011).

⁴¹ Helmer, Drew A. 2011. Stepped Care Approach to the Management of Post-Deployment Health issues. www.warrelatedillness.va.gov. (accessed October 22, 2011).

⁴² Dohrenwend, Bruce P., J. Blake Turner, Nicholas A. Turse, Ben G. Adams, Karestan C. Koenen and Randall Marshall. 2006. The Psychological Risks of Vietnam for US Veterans: A Revisit with New Data and Methods. *Science* 313, no. 5789. (August): 979-98.

⁴³ Thomas, Jeffrey L. Joshua E. Wilk, Lyndon A. Riviere, Dennis McGurk, Carl A. Castro, and Charles W. Hoge. 2010. Prevalence of Mental Health Problems and Functional Impairment Among Active Component and National Guard Soldiers 3 and 12 Months Following Combat in Iraq. *Archives of General Psychiatry*. 67, no. 6. (June): 614-623.

⁴⁴ McNally, Richard, J. 2007. Revisiting Dohrenwend et al.'s revisit of the National Vietnam Veterans Readjustment Study. *Journal of Traumatic Stress* 20. (August): 481–486.

⁴⁵ Ruzich, Michelle J., Jeffrey Looi, Leong Chee, and Michael David Robertson. 2005. Delayed Onset of Posttraumatic Stress Disorder Among Male Combat Veterans: A Case Series. *American Journal of Geriatric Psychiatry* 13, no. 5. (May): 424-427.

⁴⁶ Hiskey, Syd, Ph.D., Michael Luckie, M.S.c., Stephen Davies, M.S.c., and Chris R. Brewin, Ph.D. 2008. The Emergence of Posttraumatic Distress in Later Life: A Review. *Journal of Geriatric Psychiatry and Neurology* 21, no. 4. (December): 232-241.

⁴⁷ Fontana, Alan, F. and Robert A. Rosenheck. 2008. Treatment-seeking veterans of Iraq and Afghanistan: Comparison with veterans of previous wars. *The Journal of Nervous and Mental Disease* 196, no. 7. 513-521.

⁴⁸ Koenen, Karestan C., Jeanne Mager Stellman, Steven D. Stellman, and John F. Sommer, Jr. 2003. Risk factors for course of post-traumatic stress disorder among Vietnam veterans: A 14-year follow-up of American Legionnaires. *Journal of Consulting and Clinical Psychology* 71, (December): 980-986.

⁴⁹ Green, Bonnie L., Mary C. Grace, Jacob D. Lindy, Goldine C. Gleser, and Anthony C. Leonard. 1990. Risk factors for PTSD and other diagnoses in a general sample of Vietnam veterans. *American Journal of Psychiatry* 147, no. 6. (June): 729-733.

⁵⁰ Sutker, Patricia. B., J. Mark Davis, Madeline Uddo, and Shelly R. Ditta. 1995. War zone stress, personal resources, and PTSD in Persian Gulf War returnees. *Journal of Abnormal Psychology* 104, no. 3. (August): 444-452.

⁵¹ Armed Forces Health Surveillance Center Report. 2011. (July 2011: Deployment Health Assessments, US Armed Forces). Maryland: AFHSC.

⁵² Fontana, Alan, F. and Robert A. Rosenheck. 2008. Treatment-seeking veterans of Iraq and Afghanistan: Comparison with veterans of previous wars. *The Journal of Nervous and Mental Disease* 196, no. 7. 513-521.

⁵³ Hoge, Charles W., Artin Terhakopian, Carl A. Castro, Stephen C. Messer, and Charles C. Engel. 2007. Association of Posttraumatic Stress Disorder with Somatic Symptoms, Health Care Visits, and Absenteeism among Iraq War Veterans. *American Journal of Psychiatry* 164, no. 1. (January): 150-153.

⁵⁴ United States Department of Defense. 2011. Medical Surveillance Monthly Report. Armed Forces Health Surveillance Center. *Medical Surveillance Monthly Report*, 18, no. 9:2. September. http://www.afhsc.mil/viewMSMR?file=2011/v18_n09.pdf (accessed October 2, 2011).

⁵⁵ Taft, Casey T., Amy E. Street, Amy D. Marshall, Deborah Dowdall, and David S. Riggs. 2007. Posttraumatic stress disorder, anger, and partner abuse among Vietnam combat veterans. *Journal of Family Psychology* 21, no. 2. (June): 270-277.

⁵⁶ Monson, Candice M., Casey T. Taft, and Steffany J. Fredman. 2009. Military-related PTSD and Intimate Relationships: From Description to Theory-Driven Research and Intervention Development. *Clinical Psychology Review* 29, no. 8. (December): 707-714.

⁵⁷ *Ibid.*

⁵⁸ Teten, Andra L., Julie A. Schumacher, Casey T. Taft, Melinda A. Stanley, Thomas A. Kent, Sara D. Bailey, Nancy Jo Dunn, and Donna L. White. 2010. Intimate partner aggression perpetrated and sustained by male Afghanistan, Iraq, and Vietnam veterans with and without posttraumatic stress disorder. *Journal of Interpersonal Violence* 25, 1612-1630.

⁵⁹ Taft, Casey T., Danny G. Kaloupek, Jeremiah A. Schumm, Amy D. Marshall, Jillian Panuzio, Daniel W. King, and Terence M. Keane. 2007. Posttraumatic stress disorder symptoms, physiological reactivity, alcohol problems, and aggression among military veterans. *Journal of Abnormal Psychology* 116, no. 3. (August): 498-507.

⁶⁰ Sagalyn, Daniel. 2011. Army General Calls For Changing Name of PTSD. *Newshour (pbs.org)*. <http://214.14.134.30/ebird2/ebfiles/e20111105852600.htm> (accessed November 4, 2011).

⁶¹ Dao, James. 2010. VA is Easing Rules to Cover Stress Disorder. *New York Times*, July 7. <http://www.nytimes.com/2010/07/08/us/08vets.html> (accessed October 5, 2011).

⁶² Hoge, Charles W., Artin Terhakopian, Carl A. Castro, Stephen C. Messer, and Charles C. Engel. 2007. Association of Posttraumatic Stress Disorder with Somatic Symptoms, Health Care Visits, and Absenteeism among Iraq War Veterans. *American Journal of Psychiatry* 164, no. 1. (January): 150-153.

⁶³ Brewin, Chris W., Bernice Andrews, and John D. Valentine. 2000. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology* 68, no. 5. (October): 748-766.

⁶⁴ Stecker, Tracy, John C. Fortney, and Cathy D. Sherbourne. 2011. An intervention to increase mental health treatment engagement among OIF Veterans: a pilot trial. *Military Medicine* 176, no. 66. (June): 613-619.

⁶⁵ Gros, Daniel F., Matthew Yoder, Peter W. Tuerk, Brian E. Lozanoa, and Ron Adierno. 2011. Exposure Therapy for PTSD Delivered to Veterans via Telehealth: Predictors of Treatment Completion and Outcome and Comparison to Treatment Delivered in Person. *Behavior Therapy* 42, no. 2. (June): 276-283.

⁶⁶ Hoge, Charles W. 2011. Interview by COL Mark A. Jackson. Pentagon, Washington, D.C. November 2.

⁶⁷ Hoge, Charles W. 2011. Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are. *Journal of the American Medical Association*, 306, no. 5 (August): 549-551.

⁶⁸ National Survey on Drug Use and Health. 2008. "Treatment for Past Year Depression among Adults," *The NSDUH Report*. Washington, D.C.: Substance Abuse and Mental Health Services Administration, Department of Health and Human Services. January. <http://www.oas.samhsa.gov/2k8/depression/depressionTX.htm> (accessed October 1, 2011).

⁶⁹ National Institutes of Mental Health. 2011. Mood Disorders Fact Sheet. Maryland: National Institutes of Health, Department of Health and Human Services.

<http://report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=48&key=M> (accessed October 11, 2011).

⁷⁰ The National Alliance on Mental Illness. 2009. Depression and Veterans Fact Sheet. Virginia: NAMI. <http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88939> (accessed October 1, 2011).

⁷¹ *Ibid.*

⁷² Armed Forces Health Surveillance Center Report. 2011. (July 2011: Deployment Health Assessments, US Armed Forces). Maryland: AFHSC.

⁷³ Institute of Medicine of the National Academies. 2010. Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, D.C.: National Academies Press. <http://www.iom.edu/Reports/2010/Returning-Home-from-Iraq-and-Afghanistan-Preliminary-Assessment.aspx> (accessed October 1, 2011).

⁷⁴ United States Department of Defense. Defense Manpower Data Center. 2011. Global War on Terrorism Casualties by Military Service Component -- Active, Guard and Reserve, September 19. *Defense Manpower Data Center Data Analysis and Programs Division*.

http://siadapp.dmdc.osd.mil/personnel/CASUALTY/gwot_component.pdf (accessed September 19, 2011).

⁷⁵ The National Alliance on Mental Illness. 2009. Depression and Veterans Fact Sheet. Virginia: NAMI. <http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88939> (accessed October 1, 2011).

⁷⁶ Institute of Medicine of the National Academies. 2010. Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, D.C.: National Academies Press. <http://www.iom.edu/Reports/2010/Returning-Home-from-Iraq-and-Afghanistan-Preliminary-Assessment.aspx> (accessed October 1, 2011).

⁷⁷ *Ibid.*

⁷⁸ Quello, Susan B., Kathleen T. Brady, and Susan C. Sonne. 2005. Mood Disorders and Substance Use Disorder: A Complex Comorbidity. *Science and Practice Perspectives* 3, no. 1. (December): 13-21.

⁷⁹ Substance Abuse and Mental Health Services Administration. 2011. Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Maryland: Substance Abuse and Mental Health Services Administration.

⁸⁰ *Ibid.*

⁸¹ National Institute of Health, National Institute on Drug Abuse. 2011. Prescription Drug Abuse - May 2011. Maryland: NIDA. <http://www.nida.nih.gov/tib/prescription.html> (accessed October 1, 2011).

⁸² Substance Abuse and Mental Health Services Administration. 2011. Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Maryland: Substance Abuse and Mental Health Services Administration.

⁸³ *Ibid.*

⁸⁴ Stahre, Mandy A., Robert D. Brewer, Vincent P. Fonseca, Timothy S. Naimi. 2009. Binge drinking among US active-duty military personnel. *American Journal of Preventive Medicine* 36, no. 3. (March): 208-17.

⁸⁵ Institute of Medicine of the National Academies. 2010. Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington, D.C.: National Academies Press. <http://www.iom.edu/Reports/2010/Returning-Home-from-Iraq-and-Afghanistan-Preliminary-Assessment.aspx> (accessed October 1, 2011).

⁸⁶ Coughlin, Steven, Han Kang, and Clare Mahan. 2011. Alcohol Use and Selected Health Conditions of 1991 Gulf War Veterans: Survey Results, 2003-2005. *Preventing Chronic Disease* 8, no. 3, A53 (May): 1-5.

⁸⁷ Wilk, Joshua E., Paul D. Bliese, Paul Y. Kim, Jeffrey L. Thomas, Dennis McGurk, and Charles W. Hoge. 2010. Relationship of combat experiences to alcohol misuse among US soldiers returning from the Iraq war. *Drug and Alcohol Dependence* 108, no. 1-2. (April): 115-121.

⁸⁸ Milliken, Charles S., Jennifer L. Auchterlonie, and Charles W. Hoge. 2007. Longitudinal Assessment of Mental Health problems Among Active and Reserve Component Soldiers Returning from the Iraq War. *The Journal of the American Medical Association* 298, no. 18. (November): 2141-2148.

⁸⁹ Santiago, Patcho N., Joshua E. Wilk, Charles S. Milliken, Carl A. Castro, Charles C. Engel, and Charles W. Hoge. 2010. Screening for Alcohol Misuse and Alcohol-Related Behaviors Among Combat Veterans. *Psychiatric Services* 61, No. 6. (June): 575-581.

⁹⁰ Jacobson, Isabel G., Margaret A. K. Ryan, Tomoko I. Hooper, Tyler C. Smith, Paul J. Amoroso, Edward J. Boyko, Gary D. Gackstetter, Timothy S. Wells, and Nicole S. Bell. 2008. Alcohol Use and Alcohol-Related Problems Before and After Military Combat Deployment. *Journal of the American Medical Association* 300, no. 6. (August): 663.

⁹¹ Williamson, Vanessa and Erin Mulhall. 2011. Invisible Wounds: Psychological and Neurological Injuries Confront a New Generation of Veterans. Washington, D. C.: Iraq and Afghanistan Veterans of America. <http://java.org/content/invisible-wounds-psychological-and-neurological-injuries-confront-new-generation-veterans-0> (accessed October 1, 2011).

⁹² Saxon, Andrew J. 2011. Returning Veterans With Additions; issues and Implications for Clinical Practice. *Psychiatric Times* 28, no. 7. (July): www.psychiatrictimes.com/display/article10168/1906035 (accessed October 14, 2011).

⁹³ Dresbach, Jim. 2011. Soldier Credits ASAP for Help After Suicide Attempt. *Army.mil*. <http://www.army.mil/article/66572> (accessed October 19, 2011).

⁹⁴ Army Center for Substance Abuse Programs. 2011. "Confidential Alcohol Treatment and Education (CATEP) Findings and Recommendations." Briefing presented to Mr. Schneider, LTG Bostick and BG McGuire. Pentagon, Washington, DC., June 6.

⁹⁵ *Ibid.*

⁹⁶ The American Institute of Stress. Stress, Definition of Stress, Stressor, What is Stress?, Eustress? <http://www.stress.org/topic-definition-stress.htm> (accessed October 1, 2011).

⁹⁷ ("Killer Stress, a National Geographic Special", September 23, 2008 [aired on PBS]). www.pbs.org/programs/killer-stress/ (accessed October 2, 2011).

⁹⁸ ("Killer Stress, a National Geographic Special", September 23, 2008 [aired on PBS]) www.pbs.org/programs/killer-stress/ (accessed October 2, 2011).

⁹⁹ Capaldi, II, Vincent F., Melanie L. Guerrero, and William D.S. Killgore. 2011. Sleep disruptions among returning combat veterans from Iraq and Afghanistan. *Military Medicine* 176, no. 8. (May): 879-88.

¹⁰⁰ Nixon, P. 1979. The Human Function Curve. Adapted for *Practitioner*, 1976, no. 1302. (December): 935-44.

¹⁰¹ The American Institute of Stress. Stress, Definition of Stress, Stressor, What is Stress?, Eustress? <http://www.stress.org/topic-definition-stress.htm> (accessed October 1, 2011).

¹⁰² CBS News. 2010. Stress Vaccine? Don't Worry, Shot is on the Way, Says Dr. Robert Sapolsky. http://www.cbsnews.com/8301-504763_162-20012469-10391704.html (accessed October 1, 2011).

¹⁰³ Department of the Army. 2009. *FM 6-22.5, Combat and Operational Stress Control Manual for Leaders and Soldiers*, page 1-1. March 18.

¹⁰⁴ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

¹⁰⁵ United States Army G-1. 2011. Individual BOG:Dwell briefing. Headquarters, Department of the Army, G-1, Military Strength Analysis & Forecasting.

¹⁰⁶ United States Department of Defense. Defense Manpower Data Center. 2010. Military Family Life Project Focus on Army Spouses: Final Report. Washington, D.C.: Department of Defense.

¹⁰⁷ Insel, Thomas R., M.D. 2010. Director, National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services. Congressional Testimony. <http://www.hhs.gov/asl/testify/2010/03/t20100323a.html> (accessed September 27, 2011).

¹⁰⁸ Miovic, Michael. 2011. Military Mental Health: An Army of Children. *Psychiatric Times*, October 28. <http://www.psychiatrictimes.com/print/article/10168/1979616?printable=true> (accessed November 1, 2011).

¹⁰⁹ Frietas Williams, Rosemary. 2009. Wars Silent Stress: Healing the Military Family. *GlobalSecurity.org*. <http://sitrep.globalsecurity.org/articles/090918469-wars-silent-stress-healing-the.htm> (accessed October 1, 2011).

¹¹⁰ Science News. 2011. Length of Parental military Deployment Associated With Children's Mental Health Diagnoses, Study Finds. *ScienceDaily*. <http://www.sciencedaily.com/releases/2011/07/110704174610.htm> (accessed September 27, 2011).

¹¹¹ Frietas Williams, Rosemary. 2009. Wars Silent Stress: Healing the Military Family. *GlobalSecurity.org*. <http://sitrep.globalsecurity.org/articles/090918469-wars-silent-stress-healing-the.htm> (accessed October 1, 2011).

¹¹² msnbc.com and NBC News. 2009. Stress of war takes mental toll on military kids: Children of deployed service members at risk of psychological problems http://www.msnbc.msn.com/id/32406781/ns/health-childrens_health/t/stress-war-takes-mental-toll-military-kids/ (accessed October 1, 2011).

¹¹³ The National Child Traumatic Stress Network. 2010. Military Children and Families. <http://www.nctsn.org/resources/topics/military-children-and-families> (accessed on September 23, 2011).

¹¹⁴ Pikes Peak Area Council of Governments. 2011. Network of Care for Service Members, Veterans, and Their Families: Stress in Children and Teens. <http://pikespeak.co.networkofcare.org/library/childrenandstress.pdf> (accessed on October 1, 2011).

¹¹⁵ Einhorn, Catrin. 2011. Looking After the Soldier, Back Home and Damaged. *New York Times*, New York edition. September 27. <http://www.nytimes.com/2011/09/28/us/looking-after-the-soldier-back-home-and-damaged.html?pagewanted=all> (accessed October 17, 2011).

¹¹⁶ *Ibid.*

¹¹⁷ Office of the Chief of Public Affairs, United States Army. 2010. Army Health Promotion, Risk Reduction and Suicide Prevention Report. <http://www.army.mil/article/42934> (accessed October 18, 2011).

¹¹⁸ Shwartz, Mark. 2007. Stanford Report, "Robert Sapolsky discusses physiological effects of stress." California: Stanford University News.

¹¹⁹ Lew, Henry L., John D. Otis, Carlos Tun, Robert D. Kerns, Michael E. Clark, and David X. Cifu. 2009. Prevalence of Chronic Pain, Posttraumatic Stress Disorder, and Persistent Postconcussive Symptoms in OIF/OEF Veterans: Polytrauma Clinical Triad. *Journal of Rehabilitation Research & Development* 46, no. 6. (November): 697-702. <http://www.rehab.research.va.gov/jour/09/46/6/page697.html> (accessed October 1, 2011).

¹²⁰ *Ibid.*

¹²¹ Stein, Dr. 2010. Convergence of Posttraumatic Stress (PTS) and Postconcussive (PCS) Symptoms after mTBI. NICOE Symposium, Bethesda, Maryland. December 16-17.

¹²² Clark, Michael. 2010. Epidemiology of Pain, PTSD, and Post-concussive Syndrome among OEF/OIF Veterans. Departments of Neurology and Psychology, University of South Florida. Tampa, Florida. www.queri.research.va.gov/ptbri/docs/p3_research/clark.ppt (Accessed November 21, 2011).

¹²³ Thomas, Jeffrey, Joshua E. Wilk, Lyndon A. Riviere, Dennis McGurk, Carl A. Castro, and Charles W. Hoge. 2010. Prevalence of Mental Health Problems and Functional Impairment Among Active Component and National Guard Soldiers 3 and 12 Months Following Combat in Iraq. *Archives of General Psychiatry* 67, no. 6. (June): 614-623.

¹²⁴ Adler, David A., Kyle Possemato, Shahrzad Mavandadi, Debra Lerner, Hong Chang, Johanna Klaus, James D. Tew, David Barrett, Erin Ingram, and David W. Oslin. 2011. Psychiatric Status and Work Performance of Veterans of Operations Enduring Freedom and Iraqi Freedom. *Psychiatric Services* 62, no. 1. (January): 39-46.

¹²⁵ Department of the Army. 2011. Health Promotion & Risk Reduction Task Force Briefing presented at Active Component Strategic Reset for Law Enforcement in Garrison Conference, Arlington, Virginia. July 15.

¹²⁶ United States Army. 2011. US Army Posture Statement, (Section: "Rehabilitative Medicine."), Virginia: Department of the Army.

¹²⁷ Dao, James, Benedict Carey, and Dan Frosch. 2011. For Some Troops, Powerful Drug Cocktails have Deadly Results. *New York Times*. February 12.

¹²⁸ Page, Leigh. 2011. Report: 14% of US Troops have been prescribed opioids for pain. *The Daily*. June 23.

¹²⁹ Office of the Command Surgeon HQ, USCENTCOM and Office of the Command Surgeon US Forces Afghanistan, Office of The Surgeon General, United States Army Medical Command. 2011. Joint Mental Health Advisory Team 7 (J-MHAT 7), Operation Enduring Freedom 2010, Afghanistan. http://www.armymedicine.army.mil/reports/mhat/mhat_vii/J_MHAT_7.pdf (accessed October 28, 2011).

¹³⁰ Shinseki, Eric. 2011. Secretary, United States Department of Veterans Affairs. Remarks at the 2011 Army Medical Command Training Symposium, San Antonio, Texas. June 28.

http://www.va.gov/opa/speeches/2011/06_28_2011.asp (accessed October 3, 2011).

¹³¹ Office of the Army Surgeon General. 2010. Pain Management Task Force Final Report May 2010, page E-1, Virginia: Department of the Army.

¹³² National Institute on Drug Abuse. 2011. Prescription Drug Abuse: A Research Update. <http://www.nida.nih.gov/tib/prescription.html> (accessed October 1, 2011).

¹³³ *Ibid.*

¹³⁴ Gellad, Walid F., Brett A. Munjas, John L. Adams, Marika Suttorp, Margaret Maglione, and Elizabeth A. McGlynn. 2011. Depression Associated with Lower Medication Adherence. Rand Corporation. May 10. <http://www.rand.org/news/press/2011/05/10.html> (accessed October 27, 2011).

¹³⁵ Office of the Surgeon Multi-National Forces-Iraq, Office of The Surgeon General, United States Army Medical Command. 2008. Mental Health Advisory Team V (MHAT V), Operation Iraqi Freedom 06-08, Iraq, February 14. http://www.armymedicine.army.mil/reports/mhat/mhat_v/MHAT_V_OIFandOEF-Redacted.pdf (accessed October 1, 2011).

¹³⁶ Department of Defense. 2009. Recruiting and the All Volunteer Force (AVF). <http://www.defense.gov/news/AVF%20Handbook%202009-1.pdf> (accessed October 1, 2011).

¹³⁷ Office of the Army Surgeon General. 2010. Pain Management Task Force Final Report May 2010, page E-1, Virginia: Department of the Army.

¹³⁸ Page, Leigh. 2011. Army considers shift from just pain meds to pain management. *Becker's ASC Review*. <http://www.beckersasc.com/pain-management/army-considerss-shift-from-just-pain-meds-to-pain-management.html> (accessed on September 13, 2011).

¹³⁹ Office of the Surgeon General, United States Army Medical Command Policy, 10-076. 2010. Guidance for enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants. November 9. Department of the Army.

¹⁴⁰ *Ibid.*

¹⁴¹ All Army Activities Message. 2011. ALARACT 062/2011. Changes to Length of Authorized Duration of Controlled Substance Prescriptions in MEDCOM Regulation 40-51. February 23. Virginia: Department of the Army.

¹⁴² Kaplan, Arline. 2011. Can a Suicide Scale Predict the Unpredictable? *Psychiatric Times*. APA Conference. <http://www.psychiatrictimes.com/print/article/10168/1865745> (accessed October 11, 2011).

¹⁴³ Kochanek, Kenneth D., Jiaquan Xu, Sherry L. Murphy, Arialdi M. Miniño, and Hsiang-Ching Kung. 2011. Deaths: Preliminary Data for 2009, March 16, 2011. United States Department of Health and Human Services. *National Vital Statistics Reports* 59, no. 4. http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf (accessed October 3, 2011).

¹⁴⁴ American Association of Suicidology Fact Sheet. 2008. Suicide in the U.S.A. Based on Current (2007) Statistics. *American Association of Suicidology*. Washington, D.C. http://www.suicidology.org/c/document_library/get_file?folderId=248&name=DLFE-415.pdf (accessed October 14, 2011).

¹⁴⁵ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010. Page 16, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

¹⁴⁶ Luo, Feijun, Curtis Florence, Myriam Quispe-Agnoli, Lijing Ouyang, and Alexander Crosby. 2011. Impact of Business Cycles on US Suicide Rates, 1928-2007. *American Journal of Public Health* 101, no. 6. (June): 1139-1145.

¹⁴⁷ McIntosh, John L. 2011. U.S.A. Suicide: 2008 Official Final Data. Washington, D.C. *American Association of Suicidology*. http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-382.pdf (accessed October 14, 2011).

¹⁴⁸ American Association of Suicidology Fact Sheet. 2008. Suicide in the U.S.A. Based on Current (2007) Statistics. *American Association of Suicidology*. http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-244.pdf (accessed October 14, 2011).

¹⁴⁹ McLean, Joanne, Margaret Maxwell, Stephen Platt, Fiona Harris, and Ruth Jepson. 2008. Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review. *The Scottish Government*. <http://www.scotland.gov.uk/Publications/2008/11/28141444/5> (accessed October 11, 2011).

¹⁵⁰ United States Department of Veterans Affairs. 2010. Suicide Prevention Fact Sheet. VA Suicide Prevention Program. Washington D.C: April.

¹⁵¹ Maze, Rick. 2010. 18 Veterans commit suicide each day. *ArmyTimes*.

www.armytimes.com/news/2010/04/military_veterans_suicide_042210w/ (accessed October 12, 2011).

¹⁵² Bagalman, Erin. 2011. Congressional Research Service: *Suicide, PTSD, and Substance Use Among OEF/OIF Veterans Using VA Health Care: Facts and Figures (July 2011)*. CRS Report for Congress.

¹⁵³ Kang, Han and Tim Bullman. 2010. The Risk of Suicide among US War Veterans: Vietnam War to Operation Iraqi Freedom. Briefing presented at the 2010 DOD/VA Suicide Prevention Conference, Washington, DC. January 10-14.

¹⁵⁴ Selby, Edward A., Michael D. Anestis, Theodore W. Bender, Jessica D. Ribeiro, Matthew K. Nock, M. David Rudd, Craig J. Bryan, Ingrid C. Lim, Monty T. Baker, Peter M. Gutierrez, and Thomas E. Joiner Jr. 2010. Overcoming the fear of lethal injury: Evaluating suicidal behavior in the military through the lens of the Interpersonal-Psychological Theory of Suicide. *Clinical Psychology Review*, 30, 298-307.

¹⁵⁵ Bryan, Craig J., Kelly C. Cukrowicz, Christopher L. West, and Chad E. Morrow. 2010. Combat experience and the acquired capability for suicide. *Journal of Clinical Psychology* 66, no. 10. (October): 1044-56.

¹⁵⁶ Bryan, Craig J. and Kelly C. Cukrowicz. 2011. Associations between types of combat violence and the acquired capability for suicide. *Suicide and Life-Threatening Behavior* 41, no. 2. (April): 126-36.

¹⁵⁷ Pietrzak, Robert H., Amanda R. Russo, Qi Ling, and Steven M. Southwick. 2011. Suicidal ideation in treatment-seeking Veterans of Operations Enduring Freedom and Iraqi Freedom: the role of coping strategies, resilience, and social support. *Journal of Psychiatric Research* 45, no. 6. (June): 720-726.

¹⁵⁸ Pietrzak, Robert H., Douglas C. Johnson, Marc B. Goldstein, James C. Malley, Alison J. Rivers, Charles A. Morgan, and Steven M. Southwick. 2010. Psychosocial buffers of traumatic stress, depressive symptoms, and psychosocial difficulties in veterans of Operations Enduring Freedom and Iraqi Freedom: The role of resilience, unit support, and postdeployment social support. *Journal of Affective Disorders* 120, no. 1-3. (January): 188-192.

¹⁵⁹ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

¹⁶⁰ Larsen, Dave. 2011. NCO's Action Saves Soldier's Life. October 21. *Army Times*.

www.army.mil/article/67739 (accessed October 25, 2011).

¹⁶¹ United States Department of Defense. 2011. Weekly Suicide Update For Deaths Thru 11/06/2011. Mortality Surveillance Division, Armed Forces Medical Examiner.

¹⁶² Kinn, Julie T., Ph.D., David D. Luxton, Ph.D., Mark A. Reger, Ph.D., Gregory A. Gahm, Ph.D., Nancy A. Skopp, Ph.D., and Nigel E. Bush, Ph.D. 2011. DoDSER Calendar Year 2010 Annual Report. National Center for Telehealth and Technology, Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury.

http://t2health.org/sites/default/files/dodser/DoDSER_2010_Annual_Report.pdf (accessed October 14, 2011).

¹⁶³ Senior Medical Analyst, HP&RR Task Force. 2011. Interview by Author. Pentagon, Washington, D.C. December 15, 2011.

¹⁶⁴ United States Department of Defense. 2011. Medical Surveillance Monthly Report. Prepared by the Armed Forces Health Surveillance Center. *Medical Surveillance Monthly Report* 18, no. 4/23. (April).

¹⁶⁵ *Ibid.*

¹⁶⁶ Carson, Ed. 2010. US Won't Recover Lost Jobs Until March 2020 At Current Pace. *Investors.com*. October 8. <http://blogs.investors.com/capitalhill/index.php/home/35-politicsinvesting/2128-us-wont-recover-lost-jobs-until-march-2020-at-current-pace> (Accessed November 21, 2011).

¹⁶⁷ United States Department of Labor. Bureau of Labor Statistics. 2011. *The Employment Situation—September 2011*. <http://www.bls.gov/news.release/pdf/empst.pdf> (accessed October 17, 2011).

¹⁶⁸ Jacobe, Dennis. 2011. Gallup Finds US Underemployment Stuck at 18.5% in Mid-Sept. *Gallup.com*. <http://www.gallup.com/poll/149525/Gallup-Finds-Underemployment-Stuck-Mid-Sept.aspx> (accessed October 18, 2011).

¹⁶⁹ Bureau of Labor Statistics. 2011. Employment Situation of Veterans—2010. March 11. Washington. Department of Labor. <http://www.bls.gov/news.release/pdf/vet.pdf> (Accessed November 15, 2011).

¹⁷⁰ McLean, Joanne, Margaret Maxwell, Stephen Platt, Fiona Harris, and Ruth Jepson. 2008. Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review. *The Scottish Government*. <http://www.scotland.gov.uk/Publications/2008/11/28141444/5> (accessed October 11, 2011).

¹⁷¹ Triggle, Nick. 2011. Suicide Rates in Europe 'Linked' to Financial Crisis. *BBC News Health*. July 7. <http://www.bbc.co.uk/news/health-14068496> (accessed September 15, 2011).

¹⁷² American Foundation for Suicide Prevention. 2011. Facts and Figures. http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_ID=04EA1254-BD31-1FA3-C549D77E6CA6AA37 (accessed November 9, 2011).

¹⁷³ Fletcher, Michael. 2011. Veterans Unemployment Outpaces Civilian Rate. *The Washington Post*, October 16. http://www.washingtonpost.com/business/economy/veterans-unemployment-outpaces-civilian-rate/2011/10/04/gI0AlqLepL_story.html (accessed October 17, 2011).

¹⁷⁴ Office of the Surgeon General, United States Army Medical Command Policy 09-032. 2009. Standard Terminology for All Activities Involved in Investigating and Reporting Suicides, Suicide Attempts, Ideations, and Gesture. June 3. Department of the Army.

¹⁷⁵ United States Army G-1. 2010. Army Regulation 600-63, Army Health Promotion page 38. Virginia: Department of the Army. http://armypubs.army.mil/epubs/pdf/R600_63.PDF (accessed October 1, 2011).

¹⁷⁶ Kinn, Julie T., Ph.D., David D. Luxton, Ph.D., Mark A. Reger, Ph.D., Gregory A. Gahm, Ph.D., Nancy A. Skopp, Ph.D., and Nigel E. Bush, Ph.D. 2011. DoDSER Calendar Year 2010 Annual Report. National Center for Telehealth and Technology, Defense Centers of Excellence for Psychological Health & Traumatic Brain Injury. http://t2health.org/sites/default/files/dodser/DoDSER_2010_Annual_Report.pdf (accessed October 14, 2011).

¹⁷⁷ *Ibid.*

¹⁷⁸ Bostick, Thomas P. United States Army, Deputy Chief of Staff, G-1. 2011. Congressional Testimony on September 9.

¹⁷⁹ Office of the Surgeon General, United States Army Medical Command Policy 10-042. 2010. Release of Protected Health Information (PHI) to Unit Commanders. June 30. Virginia: Department of the Army.

¹⁸⁰ Assistant Secretary of Defense for Health Affairs. 2003 DoD Health Information Privacy Regulation 6025-18R. Paragraphs DL1.1.20 and DL1.1.28). Washington D.C.: <http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf> (accessed November 9, 2011).

¹⁸¹ *Ibid.*, Paragraph C1.2.3. <http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf> (accessed November 9, 2011).

¹⁸² All Army Activities Message. 2010. ALARACT 160/2010 (Release of PHI to Unit Command Officials), June 30. Virginia: Department of the Army.

¹⁸³ Assistant Secretary of Defense for Health Affairs. 2003 DoD Health Information Privacy Regulation 6025-18R. Paragraphs C1.2.5 and C7.11. Washington D.C.: <http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf> (accessed November 9, 2011).

¹⁸⁴ Zoroya, Gregg. 2011. Army suicide prevention efforts raising privacy concerns. *USA Today*. March 31.

¹⁸⁵ All Army Activities Message. 2010. ALARACT 160/2010 (Release of PHI to Unit Command Officials), June 30. Virginia: Department of the Army.

¹⁸⁶ *Ibid.*

¹⁸⁷ Department of the Army. 2011. Information Paper, Subject: Disability Evaluation System (DES). September 26. Virginia.

¹⁸⁸ Philpott, Tom. 2011. Disability Evaluation Reforms Seen Falling Short. *Military.com*. <http://www.military.com/features/0.15240,229094,00.html> (accessed September 25, 2011).

¹⁸⁹ Department of the Army. 2011. Temporary End Strength Increase Briefing on Integrated Disability Evaluation System. September 20. Virginia.

¹⁹⁰ Walton, Breanna. 2011. Integrated Disability Evaluation System Helps Separating Soldiers. *Army Flier Staff*. <http://www.army.mil/article/53420/integrated-disability-evaluation-system-helps-separating-soldiers/> (accessed September 25, 2011).

¹⁹¹ Department of the Army. 2011. Information Paper, Subject: Disability Evaluation System (DES). September 26. Virginia.

¹⁹² All Army Activities Message. 2010. ALARACT 160/2010 (Release of PHI to Unit Command Officials), June 30. Virginia: Department of the Army.

¹⁹³ Walton, Breanna. 2011. Integrated Disability Evaluation System Helps Separating Soldiers. *Army Flier Staff*. <http://www.army.mil/article/53420/integrated-disability-evaluation-system-helps-separating-soldiers/> (accessed September 25, 2011).

¹⁹⁴ United States Medical Command. 2011 Memorandum: New Narrative Summary (NARSUM) to Enhance the Integrated Disability Evaluation System Process. https://www.hrc.army.mil/site/Active/TAGD/Pda/IDES_NARSUM_FORMAT.pdf (accessed September 25, 2011).

¹⁹⁵ Health Promotion and Risk Reduction Task Force, Department of the Army. 2011. Data Sheets provided via email message to OPMG research team by Senior Medical Analyst. October 26, 2011.

¹⁹⁶ Hefling, Kimberly. 2011. Disability System Leaves Troops in 'Vast Unknown'. *GOPUSA.com*. August 18. <http://www.gopusa.com/news/2011/08/18/disability-system-leaves-troops-in-vast-unknown/> (accessed September 25, 2011).

¹⁹⁷ *Ibid.*

¹⁹⁸ Philpott, Tom. 2011. Invisible Injuries of War to Be Felt for Decades. *Kitsap Sun*, September 30. <http://www.kitsapsun.com/news/2011/sep/30/tom-philpott-invisible-injuries-of-war-to-be-for/> (accessed October 5, 2011).

¹⁹⁹ Department of the Army. 2011. Information Paper, Subject: Comparison of US Army and Department of Veterans Affairs (VA) Disability Ratings. September 26. Virginia.

²⁰⁰ Philpott, Tom. 2011. Disability Evaluation Reforms Seen Falling Short. *Military.com*. <http://www.military.com/features/0.15240.229094.00.html> (accessed September 25, 2011).

²⁰¹ *Ibid.*

²⁰² Bilmes, Linda and Joseph E. Stiglitz. 2011. America's Costly War Machine. <http://articles.latimes.com/2011/sep/18/opinion/la-oe-bilmes-war-cost-20110918> (accessed October 1, 2011).

²⁰³ Office of the Surgeon General, Substance Abuse and Mental Health Services Administration. 1999. Mental Health: Culture, Race, Ethnicity: A Report of the Surgeon General. www.surgeongeneral.gov/library/mentalhealth/ (accessed October 1, 2011). United States Department of Health and Human Services

²⁰⁴ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010. Glossary, Annex A. Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

²⁰⁵ Tull, Matthew, PhD. 2009. Reducing the Stigma of Mental Health Care in Veterans. *About.com Guide*. June 24. <http://ptsd.about.com/od/ptsdandthemilitary/a/stigmavets.htm> (accessed October 1, 2011).

²⁰⁶ Jowers, Karen. 2011. Mission: Family: Army officer says support programs saved his life. *Army Times*. October 31. <http://www.armytimes.com/community/family/offduty-mission-family-army-officer-says-support-program-saved-life-103111w/> (accessed November 10, 2011).

²⁰⁷ Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE). 2011. The Real Warriors Campaign: Overview. http://realwarriors.net/campaignmedia/factsheets/RW_Overview.pdf (accessed October 15, 2011).

²⁰⁸ *Ibid.*

²⁰⁹ Under Secretary of Defense (Personnel and Readiness). 2011. Department of Defense Instruction 6490.08 - Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members. Virginia: Department of Defense. <http://www.dtic.mil/whs/directives/corres/pdf/649008p.pdf> (accessed October 1, 2011).

²¹⁰ United States Army G-1. 2010. Army Regulation 600-63, Army Health Promotion. Virginia: Department of the Army. http://armypubs.army.mil/epubs/pdf/R600_63.PDF (accessed October 1, 2011).

²¹¹ *Ibid.*

²¹² Williams, Darryl A. and CSM Scott. 2011. Warrior Care and Transition Program Update to the VCSA and Senior Commanders. October 19. Virginia: United States Army Warrior Transition Command.

²¹³ United States Army Medical Command. 2011. Soldier Medical Readiness Campaign Plan 2011 – 2016, Version 1.2. Virginia: Department of the Army. http://www.armymedicine.army.mil/news/docs/SMR_CP_Version_1.2.pdf (accessed October 1, 2011)

²¹⁴ United States Army Warrior Transition Command. 2011. Briefing to the DoD Task Force on the Care, Management and Transition of Recovering Wounded, Ill and Injured Members of the Armed Forces. February 22. Virginia: Department of the Army. <http://dtf.defense.gov/rwtf/m02/m02pa02.pdf> (accessed October 28, 2011).

²¹⁵ Williams, Darryl A. 2011. Warrior Care and Transition Program Update to the VCSA and Senior Commanders. October 19. Virginia: United States Army Warrior Transition Command.

²¹⁶ United States Army Warrior Transition Command. 2011. Virginia: Department of the Army. http://wtc.army.mil/about_us/wtu.html (accessed on October 28, 2011).

²¹⁷ United States Army Medical Command. 2011. Soldier Medical Readiness Campaign Plan 2011 – 2016, Version 1.2. Virginia: Department of the Army. http://www.armymedicine.army.mil/news/docs/SMR_CP_Version_1.2.pdf (accessed October 1, 2011).

²¹⁸ Carino, Michael. 2011. Warrior Transition Population: Overview, Trend, and Outcome Metrics. September 19. Virginia: Office of the Army Surgeon General.

²¹⁹ *Ibid.*

²²⁰ *Ibid.*

²²¹ *Ibid.*

²²² *Ibid.*

²²³ Williams, Darryl A. 2011. Warrior Care and Transition Program Update to the VCSA and Senior Commanders. October 19. Virginia: United States Army Warrior Transition Command.

²²⁴ United States Army Medical Command. 2011. Soldier Medical Readiness Campaign Plan 2011 – 2016, Version 1.2. Virginia: Department of the Army. http://www.armymedicine.army.mil/news/docs/SMR_CP_Version_1.2.pdf (accessed October 1, 2011).

²²⁵ United States Army Warrior Transition Command. 2011. Briefing to the DoD Task Force on the Care, Management and Transition of Recovering Wounded, Ill and Injured Members of the Armed Forces. February 22. Virginia: Department of the Army. <http://dtf.defense.gov/rwtf/m02/m02pa02.pdf> (accessed October 28, 2011).

²²⁶ Williams, Darryl A. 2011. Warrior Care and Transition Program Update to the VCSA and Senior Commanders. October 19. Virginia: United States Army Warrior Transition Command.

²²⁷ Casey, George W. Jr. 2011. Comprehensive Soldier Fitness: A Vision for Psychological Resilience in the US Army. *American Psychologist*, 66, no. 1. (January): 1-3.

²²⁸ Siebert, Al. 2011. Founder and Director of the Resiliency Center. <http://resiliencycenter.com/index.shtml> (accessed November 9, 2011).

²²⁹ Comprehensive Soldier Fitness. 2011. Strong Minds, Strong Bodies. <http://csf.army.mil> (accessed October 15, 2011).

²³⁰ Jaffe, Greg, 2011. Soldier finds love after losing both legs in Afghanistan. *Washington Post*. http://www.washingtonpost.com/world/national-security/love-for-wounded-soldier-upon-return-from-afghanistan/2011/10/03/gIQAdaGSWL_story.html (accessed November 9, 2011).

²³¹ Adler, Amy B., Paul D. Bliese, Dennis McGurk, Charles W. Hoge, and Carl A. Castro. 2009. Battlemind Debriefing and Battlemind Training as early interventions with Soldiers returning from Iraq: randomization by platoon. *Journal of Consulting and Clinical Psychology*, 79, no. 5. (October): 928-940. <http://www.ncbi.nlm.nih.gov/pubmed/19803572> (accessed November 9, 2011).

²³² Green, Kimberly T., Patrick S. Calhoun, Michelle F. Dennis, the Mid-Atlantic Mental Illness Research, Education and Clinical Center Workgroup, and Jean C. Beckham. 2010. Exploration of the Resilience Construct in Post Traumatic Stress Severity and Functional Correlates in Military Combat Veterans who have served since September 11th, 2001. *Journal of Clinical Psychiatry*, 71, no. 1. (July): 823-830.

²³³ Comprehensive Soldier Fitness. 2011. Strong Minds, Strong Bodies. <http://csf.army.mil> (accessed October 15, 2011).

²³⁴ Comprehensive Soldier Fitness. 2011. The Comprehensive Soldier Fitness Program Evaluation. Report #3: Longitudinal Analysis of the Impact of Master Resilience Training on Self-Reported Resilience and Psychological Health Data. November 2011. Arlington, Virginia.

²³⁵ Department of Health and Human Services. 2008. Substance Abuse and Mental Health Services Administration (SAMHSA), Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment 2004-2014. <http://store.samhsa.gov/shin/content//SMA08-4326/SMA08-4326.pdf> (accessed October 1, 2011).

²³⁶ Comprehensive Soldier Fitness. 2011. Brochure Update (Version 3). <http://csf.army.mil> (accessed October 15, 2011).

²³⁷ Director, VCSA Strategic Communications Team. 2011. Interview by Author. Pentagon, Washington, D.C. October 15, 2011.

²³⁸ United States Army G-1. 2011. Initial Entry Training (IET) Attrition Brief. December 1. Virginia: Department of the Army .

²³⁹ United Army Recruiting Command. 2011. Support Army Recruiting: Frequently Asked Questions about Recruiting. Kentucky. <http://www.2k.army.mil/faqs.htm> (accessed October 3, 2011).

²⁴⁰ Lester, Paul B., P.D. Harms, Denise J. Bulling, Mitchel N. Herian, and Seth M. Spain. 2011. Evaluation of Relationships Between Reported Resilience and Soldier Outcomes," Report #1: Negative Outcomes (Suicide, Drug Use and Violent Crimes). February. <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA538618&Location=U2&doc=GetTRDoc.pdf> (accessed November 9, 2011).

²⁴¹ Salo, Mikael and Guy Siebold. 2006. US Army Research Institute for the Behavioral and Social Sciences, Predictors of Attrition in the Finnish Conscript Service. November. http://www.hqda.army.mil/ari/pdf/TR_1192.pdf (accessed November 9, 2011).

²⁴² Alzheimer's Association. 2011 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia*, Volume 7, Issue 2. http://www.alz.org/downloads/Facts_Figures_2011.pdf (accessed November 1, 2011).

²⁴³ Army Study To Assess Risk and Resilience in Servicemembers. 2011. www.armystarrs.org (accessed November 9, 2011).

²⁴⁴ Framingham Heart Study. 2011. A Project of the National Heart, Lung, and Blood Institute and Boston University. www.framinghamheartstudy.org (accessed November 1, 2011).

²⁴⁵ National Institute of Mental Health. 2009. The Making of Army-STARRS: an Overview. <http://www.nimh.nih.gov/health/topics/suicide-prevention/suicide-prevention-studies/the-making-of-army-starrs-an-overview.shtml> (accessed November 1, 2011).

²⁴⁶ National Intrepid Center of Excellence. <http://www.dcoe.health.mil/ComponentCenters/NICoE.aspx> (accessed November 9, 2011).

²⁴⁷ National Intrepid Center of Excellence. 2011. NICoE Fact Sheet. Fall 2011. <http://www.dcoe.health.mil/Content/Navigation/Documents/About%20NICoE.pdf> (accessed October 1, 2011).

²⁴⁸ Chiarelli, Peter. 2011. "Congressional Mental Health Caucus Briefing." May 12. (Information provided by Laura Watson, Office of the Vice Chief of Staff of the Army, December 5 2011.)

²⁴⁹ Miles, Donna. 2011. Intrepid Center Marks First Anniversary. *American Forces Press Service*. June 24. <http://www.defense.gov/news/newsarticle.aspx?id=64450> (accessed October 1, 2011).

²⁵⁰ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010, Glossary, Annex A. Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

²⁵¹ United States Army G-1. 2011. Army Regulation, 600-85, Army Substance Abuse Program. Virginia: Department of the Army. http://www.apd.army.mil/pdffiles/r600_85.pdf (accessed November 18, 2011).

²⁵² United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

²⁵³ United States Army G-1. 2011. Army Regulation, 600-20, Army Command Policy. Virginia: Department of the Army. http://www.apd.army.mil/pdffiles/r600_20.pdf (accessed November 18, 2011).

²⁵⁴ *Ibid.*

²⁵⁵ Manual for Courts-Martial United States, 2008 Edition. <http://www.scribd.com/doc/25965491/Manual-for-Courts-martial-United-States-2008-Edition> (accessed November 15, 2011).

²⁵⁶ United States Army G-1. 2011. Army Regulation, 600-20, Army Command Policy. Virginia: Department of the Army. http://www.apd.army.mil/pdffiles/r600_20.pdf (accessed November 18, 2011).

²⁵⁷ United States Army. 2011. 38th Chief of Staff, Army Initial Guidance and Thoughts. September 14. <http://www.army.mil/leaders/csa/> (accessed October 28, 2011).

²⁵⁸ United States Army, Office of the Provost Marshal General. 2011. Army Regulation, 195-2, Criminal Investigation Activities. Virginia: Department of the Army. http://www.apd.army.mil/pdffiles/r195_2.pdf (accessed October 28, 2011).

²⁵⁹ Operations Research and System Analysis, Army Combat Readiness/Safety Center. Data Sheets provided via email message to OPMG research team by Division Chief, ORSA/CRC. October 31, 2011.

²⁶⁰ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

²⁶¹ Monson, Candice M., Casey T. Taft, and Steffany J. Fredman. 2009. Military-related PTSD and Intimate Relationships: From Description to Theory-Driven Research and Intervention Development. *Clinical Psychology Review* 29, no. 8. (December): 707-714.

²⁶² Institute of Medicine of the National Academies. 2010. Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment Needs of Veterans, Service Members, and Their Families. Washington,

D.C.: National Academies Press. <http://www.iom.edu/Reports/2010/Returning-Home-from-Iraq-and-Afghanistan-Preliminary-Assessment.aspx> (accessed October 11, 2011).

²⁶³ Zucchino, David. 2011. Veteran's Murder Trial Tests Limits of PTSD As Defense. *Los Angeles Times*. September 15. <http://214.14.134.30/ebird2/ebfiles/e20110915841995.html>. (accessed September 15, 2011).

²⁶⁴ United States Department of Justice. 2009. Uniform Crime Reporting (UCR) Offense Definitions. January 23. <http://www.ucrdatatool.gov/offenses.cfm> (accessed November 19, 2011).

²⁶⁵ Leger, Donna . 8.9% of College-Age Adults Use Drugs. *USA Today*. September 9, 2011.

²⁶⁶ Santiago, Patcho N., Joshua E. Wilk, Charles S. Milliken, Carl A. Castro, Charles C. Engel, and Charles W. Hoge. 2010. Screening for Alcohol Misuse and Alcohol-Related Behaviors Among Combat Veterans. *Psychiatric Services* 61, No. 6. (June): 575-581.

²⁶⁷ Schultz, Michael. 2011. Sustaining the Force. *Warrior Citizen*. Summer 2011. http://issuu.com/warriorcitizen/docs/wc_summer_2011?mode=embed&layout=http://skin.issuu.com/v/light/layout.xml&showFlipBtn=true (accessed November 2, 2011).

²⁶⁸ Hawley, Chris. 2011. An Epidemic: Pharmacy Robberies Sweeping US. *MSNBC.com*. June 25. http://www.msnbc.msn.com/id/43536286/ns/us_news-crime_and_courts/t/epidemic-pharmacy-robberies-sweeping-us/ (accessed October 27, 2011).

²⁶⁹ United States Department of Defense, Chairman of the Joint Chiefs of Staff memorandum. 2010. A Systems Approach to Drug Demand Reduction in the Force. November 1.

²⁷⁰ United States Army G-1. 2011. Army Regulation, 600-85, Army Substance Abuse Program. Virginia: Department of the Army. http://www.apd.army.mil/pdffiles/r600_85.pdf (accessed November 18, 2011).

²⁷¹ Harris, Elizabeth A. 2011. D.E.A. Bans Chemicals Used in Bath Salts. *The New York Times*. October 22. http://www.nytimes.com/2011/10/22/us/dea-bans-chemicals-used-in-bath-salts.html?_r=1 (accessed November 5, 2011).

²⁷² Kelly, Ursula A., Kelly Skelton, Meghna Patel, and Bekh Bradley. 2011. More than military sexual trauma: Interpersonal violence, PTSD, and mental health in women veterans. December 2011. *Research and Nursing Health* 34, no. 6. (December): 457-467.

²⁷³ Maguen, Shira, Beth Cohen, Li Ren, Jeane Bosch, Rachel Kimerling, and Karen Seal. 2011. Gender Differences in Military Sexual Trauma and Mental Health Diagnoses Among Iraq and Afghanistan Veterans With Posttraumatic Stress Disorder. September 8. *Womens Health Issues*, epublication ahead of print. http://www.researchgate.net/publication/51639066_Gender_Differences_in_Military_Sexual_Trauma_and_Mental_Health_Diagnoses_Among_Iraq_and_Afghanistan_Veterans_With_Posttraumatic_Stress_Disorder (accessed November 10, 2011).

²⁷⁴ United States Army, Office of the Provost Marshal General. 2011. CID Operations Memorandum 06-11, ACI2 System Update. April 27. Pentagon. Arlington, Virginia.

²⁷⁵ Pusateri, Sarah. 2011. Military Sexual Trauma: The Other Horror of War. *HealthyState.org*. November 10. <http://healthystate.org/2011/11/military-sexual-trauma-the-other-horror-of-war/> (accessed November 11, 2011).

²⁷⁶ Connors, Edward, Thomas Lundregan, Neal Miller, and Tom McEwen. 1996. Convicted by Juries, Exonerated by Science: Case Studies in the Use of DNA Evidence to Establish Innocence After Trial. United States Department of Justice. <https://www.ncjrs.gov/pdffiles/dnaevid.pdf> (accessed November 13, 2011).

²⁷⁷ Gross, Bruce. 2009. False Rape Allegations: An Assault on Justice. *The Forensic Examiner*. Spring 2009. <http://www.theforensicexaminer.com/archive/spring09/15/> (accessed November 12, 2011).

²⁷⁸ G-1 Specialist. Interview by COL Mark A. Jackson. Pentagon, Washington, D.C. December 9.

²⁷⁹ Ramsberger, Peter F. and D. Bruce Bell. 2002. What We Know About AWOL and Desertion: A Review of the Professional Literature for Policy Makers and Commanders. *US Army Research Institute*. August. <http://www.hqda.army.mil/ari/pdf/s51.pdf> (accessed November 13, 2011).

²⁸⁰ All Army Activities Message. 2011. ALARACT 366/2011. Guidance for Commanders Request to Enter Deserter Warrants into the National Crime Information Center Database. September 2011. Virginia: Department of the Army.

²⁸¹ All Criminal Investigation Command Message. 2011. ALCID 020-11. Commander Monitoring of Persons under Investigation. October 2011. Virginia: Department of the Army.

²⁸² Eaton, Karen M., Stephen C. Messer, Abigail L. Garvey Wilson and Charles W. Hoge. 2006. Strengthening The Validity of Population-Based Suicide Rate Comparisons: An Illustration Using US Military and Civilian Data. *Suicide and Life-Threatening Behavior* 36, no. 2, (April): 183.

²⁸³ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

²⁸⁴ Health Promotion and Risk Reduction Task Force, Department of the Army. 2011. Data Sheets provided via email message to OPMG research team by Senior Medical Analyst. October 18, 2011.

²⁸⁵ Distifeno, Chris. 2008. Effects of Moral Conduct Waivers on First-Term Attrition of US Soldiers. Master's thesis, Naval Postgraduate School.

²⁸⁶ Malone, Lauren, Neil Carey, Yevgeniya Pinelis, and Dave Gregory. 2011. Waivered Recruits: An Evaluation of Their Performance and Attrition Risk. *Center for Naval Analyses*. March. Virginia.
<http://www.stormingmedia.us/90/9021/A902145.html> (accessed November 9, 2011).

²⁸⁷ United Army Recruiting Command. 2011. Support Army Recruiting: Frequently Asked Questions about Recruiting. Kentucky. <http://www.2k.army.mil/faqs.htm> (accessed October 3, 2011).

²⁸⁸ All Army Activities Message. 2011. ALARACT 386/2011, Suspension of Favorable Personnel Actions (Flags), October 2011. Virginia: Department of the Army.

²⁸⁹ Jedrzejczak, M. and Blaszczyk, J. 2005. Attitudes of soldiers taking drugs to military service, training, and discipline. *Journal of Military Medicine*, 170. 691-695.

²⁹⁰ United States Army. 2010. Army Health Promotion Risk Reduction Suicide Prevention Report 2010. Page 164, Virginia: Prepared by the Army Suicide Prevention Task Force, Headquarters, Department of the Army.

